

SECTION I: ACH LEVEL

ACH	Better Health Together
Name	Hadley Morrow
Phone Number	509-954-0831
E-mail	hadley@betterhealthtogether.org

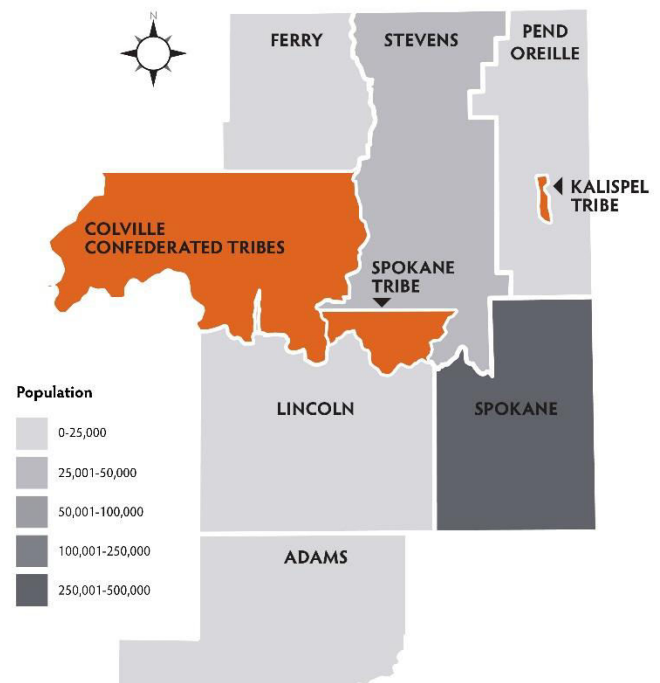
Regional Health Needs Inventory

Regional Health Needs Inventory

How Better Health Together (BHT) has used data to inform its project selection and planning

BHT ACH has used data to: assess needs, resources, and interest in different aspects of transformation; to engage providers and potential partners; to inform strategic direction and prioritization discussions; and to illuminate areas where more data and analysis are needed as project planning continues into implementation design.

BHT ACH has existed since 2013 as a regional organization dedicated to improving health and community systems of care for all residents. In this role, BHT's staff, Leadership Council, and Board reviewed available data about community-wide health needs and resources and hosted numerous conversations to better understand communities' perspectives on bright spots and to identify health disparities (see Community Engagement section). These conversations uncovered several key concerns including access to care, chronic disease, obesity, Adverse Childhood Experiences, and inadequate access to and coordination of community resources, which were summarized in fall 2016 and can be viewed in Appendix 1.



Since approval of the Medicaid Transformation Demonstration (MTD) and publication of the Project Toolkit, BHT ACH has used a range of data to consider the needs of Medicaid beneficiaries in particular and to assess current performance and capacity in the eight potential Demonstration project areas, as well as Domain 1. The goal of this stage of assessment has been to identify opportunities for real improvement and explore areas where MTD work can help drive community priorities.

Several data sources have informed BHT ACH's iterative **project selection and planning** process:

- BHT ACH collected data from partners and community members to inform project selection via an open call for Letters of Interest (LOIs) for community projects in the six optional MTD project areas. LOIs were received from 40 different organizations or partnerships across all six of BHT ACH's counties. While all project areas were represented, over half of the proposals involved care coordination across sectors.
- Nineteen of the LOI participants were selected for a community showcase event in August 2017, where organizations briefly described their projects and community members participated in a voting exercise to indicate their interest in and support for different ideas. Proposals involving care coordination received the largest share of votes during the community feedback event. There was interest in each of the remaining optional project area as well, but no clear prioritization among them. See Appendix 2 for summaries of showcase feedback.
- In the summer of 2017, BHT ACH surveyed its health system and community-based organization partners about their interest, capacity, and priorities for Demonstration-related work (including Domain 1 strategies). Thirty-nine organizations submitted either a Health Systems Inventory or Care Coordination Inventory (HSI or CCI). While there was interest across all project areas, responses were most concrete for bi-directional integration (2A), care coordination (2B), opioids (3A), and chronic disease (3D). In other project areas, likely partners had less experience or fewer tangible priorities, or did not express support for the specific evidence-based strategies highlighted in the MTD Toolkit. Data from the HSI and CCI also highlighted client needs around mental health, substance abuse, chronic diseases, and social determinants of health (e.g. insecure housing). HSI and CCI results are described in more detail later in this section.
- As datasets or reports like the Regional Health Needs Inventory 'starter set' files, HCA Provider reports, or partner publications such as the Spokane Urban Indian Health Profile became available, BHT staff and contractors reviewed them to inform project selection and planning. Review and analysis have encompassed issues including but not limited to:
 - Population size and disease burden (e.g. how many Medicaid members in BHT ACH region have both a chronic disease and mental health or substance abuse need?);

- Disparities based on demographics, and geography, and other factors;
- Current performance on MTD quality measures and potential for impact (e.g. how does BHT ACH compare to state and national averages for asthma medication management based on current publicly available data?).

Many of these exploratory analyses have been shared with BHT leadership and partners as we considered project selection and priorities. Two slide presentations, from a September Board meeting and October community learning webinar, are attached as examples (Appendices 3 and 4).

Project planning is of course ongoing. As the BHT ACH and our partners move deeper into project design and implementation planning, we will continue to use data for multiple purposes, including but not limited to: honing in on target populations and partnering providers (e.g. EDs seeing the largest volume of ‘high utilizers’ with behavioral health conditions); estimating potential impact (e.g. estimating the number of readmissions to be avoided in order to meet improvement targets); or assessing the potential viability of proxy measures for performance improvement (e.g. can unintended pregnancy rates be reliably measured at a regional level?).

To the extent possible, the BHT ACH plans to provide tailored data to each of its Community Health Transformation Collaboratives for their use in planning, monitoring, and continuous improvement. (The Collaboratives are comprised of health system and social determinant of health partners serving as the activation network for implementation of the MTD projects; see Theory of Action section for more description). The BHT ACH also plans to disaggregate data (by race, ethnicity, geography, eligibility group, and other relevant categories) wherever possible to inform decisions about target populations and monitor the impact of projects across diverse groups.

The BHT ACH has engaged with the Providence Center for Outcomes Research and Education (CORE) to support our data and analytic needs, including accessing and analyzing data to inform project selection and developing plans for monitoring and continuous improvement during project implementation. CORE is an independent research team with expertise in data science, evaluation, and collaborative research. CORE’s staff have extensive experience in Accountable Community of Health and Medicaid redesign initiatives in Oregon, California, and Washington. The BHT ACH also leverages a shared learning partnership with the Pierce County and Southwest Washington ACHs and connects regularly with data and analytic resources in the region including the Spokane Regional Health District and Eastern Washington University’s Institute for Public Policy and Economic Analysis.

Data sources

The BHT ACH has consulted a wide range of data sources to date. These are summarized in the RHNI Data Sources & Uses Table (Appendix 5). The sources include:

- HCA or Department of Social and Health Services – Research and Data Analysis (RDA) data products produced specifically for ACHs (e.g. RDA measure decomposition files, suppressed data tables for co-occurring disorders, Provider Report, etc.)
- State data for either the Medicaid or the general population (e.g. Opioid Overdose Dashboard;¹ Washington DOH regional chronic disease profiles;² Washington State Office of Financial Management report on Potentially Avoidable Hospitalizations³)
- Existing data or reports from BHT ACH's region (e.g. The NATIVE Project / Spokane Urban Indian Health Center Community Profile)
- Primary data collected by the BHT ACH from partnering providers—including health care providers, Medicaid Managed Care Organizations, and Community-based Organizations—to inform project selection and planning. The two most significant examples of original data collected from partnering organizations are described below: BHT ACH's Health Systems and Care Coordination Inventories (briefly referenced above) and the BHT ACH/Spokane Regional Health District Community Linkages Study.

The **Health System and Care Coordination Inventories** (HSI and CCI, see Appendices 6 and 7) collected information on organizations' Medicaid patients/clients and service characteristics, including health status and leading diagnoses. The inventories also queried partners directly about their interest, capacity, and priorities for MTD-related work. The BHT ACH received HSI responses from 23 organizations in the region, including major hospital networks, provider systems, and FQHCs. Twenty-six (26) CCIs were returned from community-based organizations. Three of the five Medicaid Managed Care Organizations also completed CCIs; these MCOs represent 73% of the Medicaid-enrolled population in BHT's region.⁴ See Appendix 8 for the list of HSI and CCI respondents (organizations that submitted project Letters of Interest are also included).

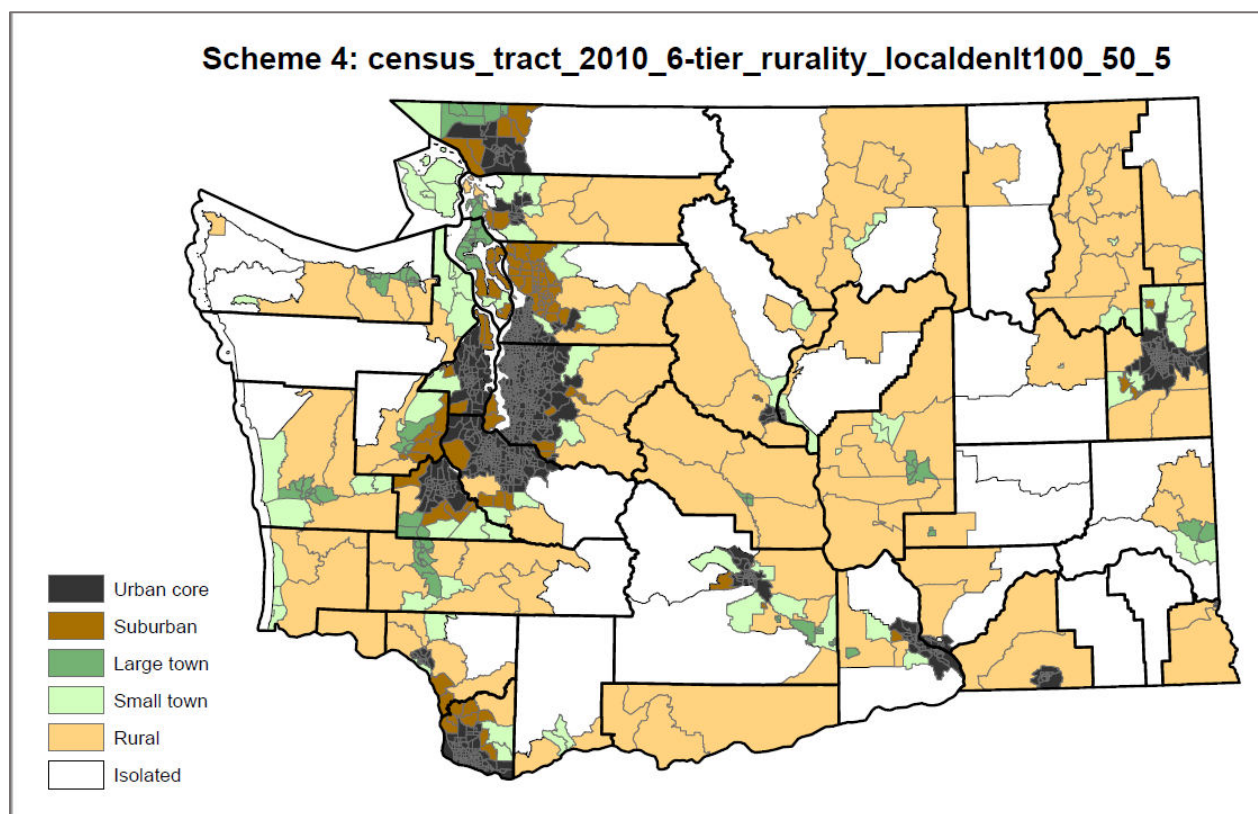
The BHT ACH compared the HSI respondents with HCA's September 2017 Provider Report⁵ and found that the inventory responses represent more than 80% of the highest (top 10) volume Medicaid billers in each major setting (primary care, mental health/substance abuse, inpatient and ED.) For several settings in the BHT ACH's five rural counties, the HSI respondents represent *all* the Medicaid billers with claims or beneficiary counts of more than 10 in 2016. BHT staff are following up with non-represented providers that see a large number of Medicaid clients, particularly substance abuse disorder treatment, oral health and Indian Health Services providers.

In 2016, the Spokane Regional Health District conducted a large scale **Community Linkage Mapping** and social network analysis,⁶ in which 165 individuals representing 112 organizations from the health, social service, education, business, and public sectors completed a Population and Social Determinants of Health Systems Survey. Because participants were able to describe their linkages with organizations that did not respond directly, the report in fact represents 564 organizations and is the most comprehensive picture available of health-relevant community-based resources in the BHT ACH region. A full list of represented organizations by geography and sector can be found in Appendix 9.

Medicaid Beneficiary Population Profile

BHT ACH has a large service region, which covers 12,273 square miles and is predominately rural. An urban core exists in Spokane and there is a surrounding suburban commuting area. 84% of the region's population lives in Spokane County⁷ and many areas in Ferry, Lincoln, and Adams counties are classified as isolated, as shown in the map below.

Figure 1: Washington State 6-Tier rural categorization by census tract (2010)⁸



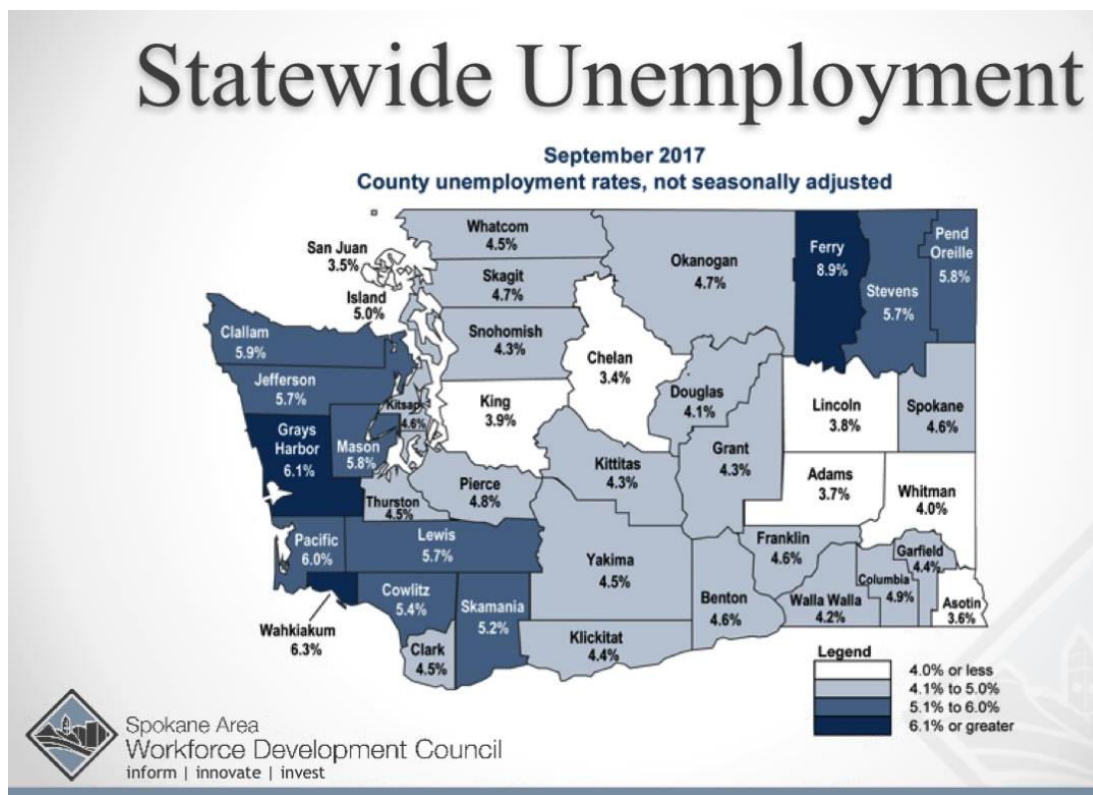
BHT ACH has approximately 196,000 Medicaid members,⁹ which represents a higher proportion of the population than the state as a whole (33% Medicaid coverage vs. 28% statewide).¹⁰ Adams County has the highest proportional Medicaid population in the state, at 52%. Following

the general population distribution, most of BHT ACH's Medicaid population lives in Spokane County.

On the whole, BHT ACH's Medicaid population is: slightly older and more male than the state Medicaid population; more likely to be white (75% compared to 57.0% statewide); less likely to be Hispanic (11% compared to 21.0% statewide); and more likely to give English as their preferred language (94% vs. 83% statewide). However, there is real variation within the BHT ACH region. For example, Adams County Medicaid beneficiaries are younger (68% under 19), more Hispanic (78%), and 46% identify Spanish as their preferred language.¹¹ Individuals who identify as Hispanic are a growing proportion of the population in all of BHT ACH's counties, as they are statewide.¹² In Stevens and Ferry counties, where Spokane tribal lands and part of the Colville Tribal lands are located, 10% and 27% of Medicaid enrollees (respectively) identify as American Indian or Alaska Native.¹³ These numbers are significant given ongoing disparities in health care access and outcomes among Native groups.

BHT ACH's northern counties have some of the highest unemployment rates in the state: Ferry County leads the state at 8.7% unemployment as of September 2017 and Pend Oreille and Stevens Counties are both close to 6%.

Figure 2: Washington State Unemployment Rates, September 2017¹⁴



Similarly, the three northeast counties have higher-than average proportions of children in poverty (27% in Stevens; 31% for Ferry and Pend Oreille).¹⁵ In Spokane County, more than a third of the American Indian/Alaska Native (AI/AN) population is below the poverty line and unemployment for AI/AN residents is close to 20%.¹⁶ According to the 2015 Washington State Housing Needs Assessment, all BHT ACH counties have low numbers of affordable housing units, with Spokane County the lowest at 12 affordable and available units per 100 households.¹⁷

BHT ACH's Health System Inventory respondents with available data reported that between 3% and 18% of their clients live in housing that is either not stable or is overcrowded and that as many as 15% have a history of incarceration. However, many noted they had no mechanism to track this type of information.

Table 1: Client need estimates from BHT's Health Systems Inventory¹⁸

BHT ACH HSI Respondents on their patients/clients' needs	Range
% Children in foster care	0% - 10%
% Clients with insecure or inadequate housing	3% - 18%
% Clients with a history of incarceration	0% - 15%

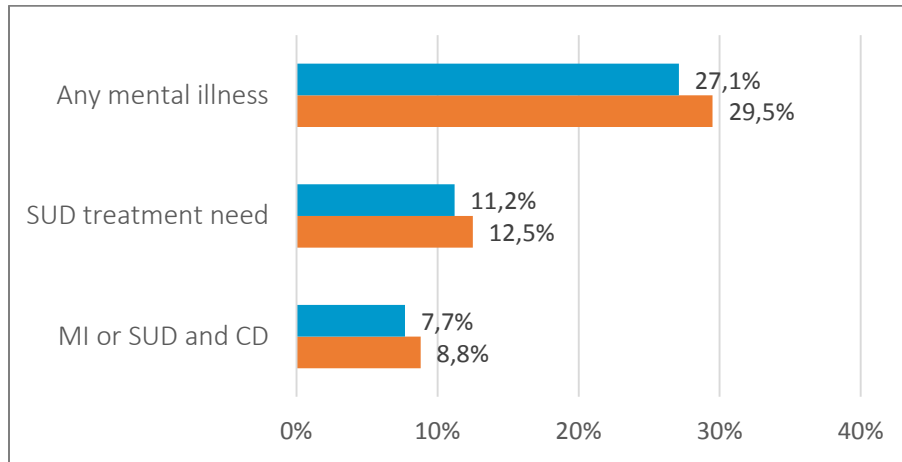
Historical data for the Medicaid Transformation Demonstration performance measures, which are more narrowly defined to Medicaid beneficiaries and events in the last year, put the rate of homelessness among BHT ACH Medicaid enrollees at 3.8% (below the statewide average) and past-year arrests at 6.5%.¹⁹

Medicaid beneficiary population health status

Behavioral Health conditions and treatment needs are widespread

More than 44,000 BHT ACH Medicaid members (almost 30%) have been diagnosed with a mental illness and approximately 20,000 (12%) have a substance abuse treatment need. About 36,000 (9%) have a mental health or substance abuse condition *and* 1 or more chronic diseases. These figures represent a larger segment of the Medicaid population for BHT ACH than the corresponding figures for Washington as a whole.

Figure 3: Prevalence of chronic conditions among BHT ACH area Medicaid beneficiaries, FY2015-16²⁰



Outside of pregnancy and childbirth, ‘mental and behavioral disorders’ were the leading cause of hospitalization for BHT ACH Medicaid beneficiaries in 2015, accounting for 17.5% of all non-birth-related hospitalizations. Substance abuse disorders accounted for 5.7% of such hospitalizations overall but 8% among non-disabled adults.²¹

BHT ACH’s Health System Inventory respondents supplied information about the most frequent diagnoses among their patients/clients. Mental health conditions represented 23% of top 5 diagnoses, and substance abuse or addiction represented 6%.²²

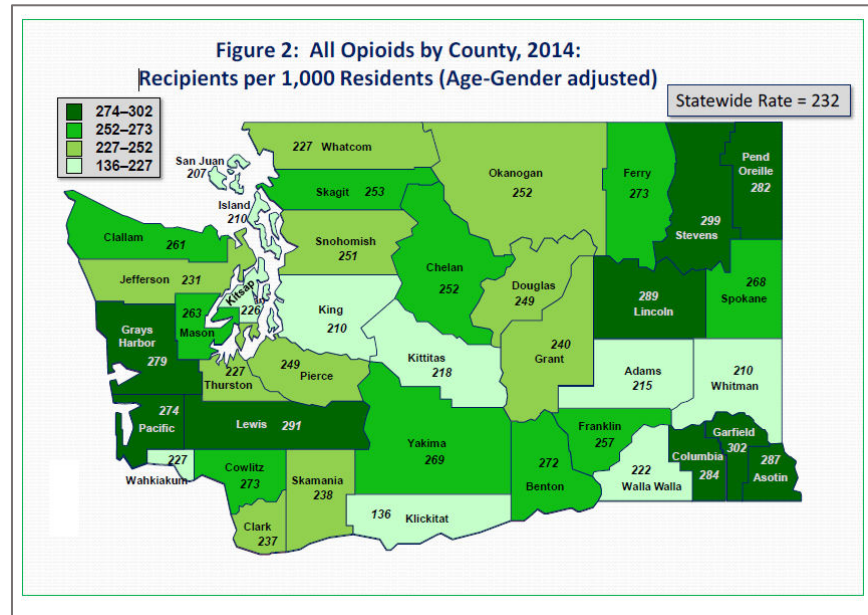
Opioid use is high among BHT ACH’s Medicaid population. 17.4% of BHT ACH Medicaid beneficiaries are current opioid users (vs. 13.5% statewide) and 3.6% are heavy users.

Table 2: Medicaid beneficiary opioid use, BHT vs. Washington State²³

Opioid Users as % of Medicaid population	BHT	Washington
All	17.4%	13.5%
Users without cancer	15.4%	11.9%
Heavy Users	3.6%	2.8%
Users for > 30 days	3.9%	2.8%

In almost all of BHT ACH’s counties, opioid prescriptions are written and filled at a higher rate than average for Washington state. (Adams County is the exception.)

Figure 4: Opioid prescriptions written and filled per 1,000 residents, 2014²⁴



BHT ACH is substantially below the state average for Medicaid opioid users receiving medication-assisted treatment with methadone (11% vs. 16% statewide) but is at about the statewide average for MAT with buprenorphine (11% vs. 10% statewide).²⁵

BHT ACH is a little below the state average for mental health treatment and substance abuse treatment penetration rates among Medicaid beneficiaries. However, rates of follow-up after a hospitalization or ED visit related to mental health or substance use are higher than the average for Washington state.^{26 19}

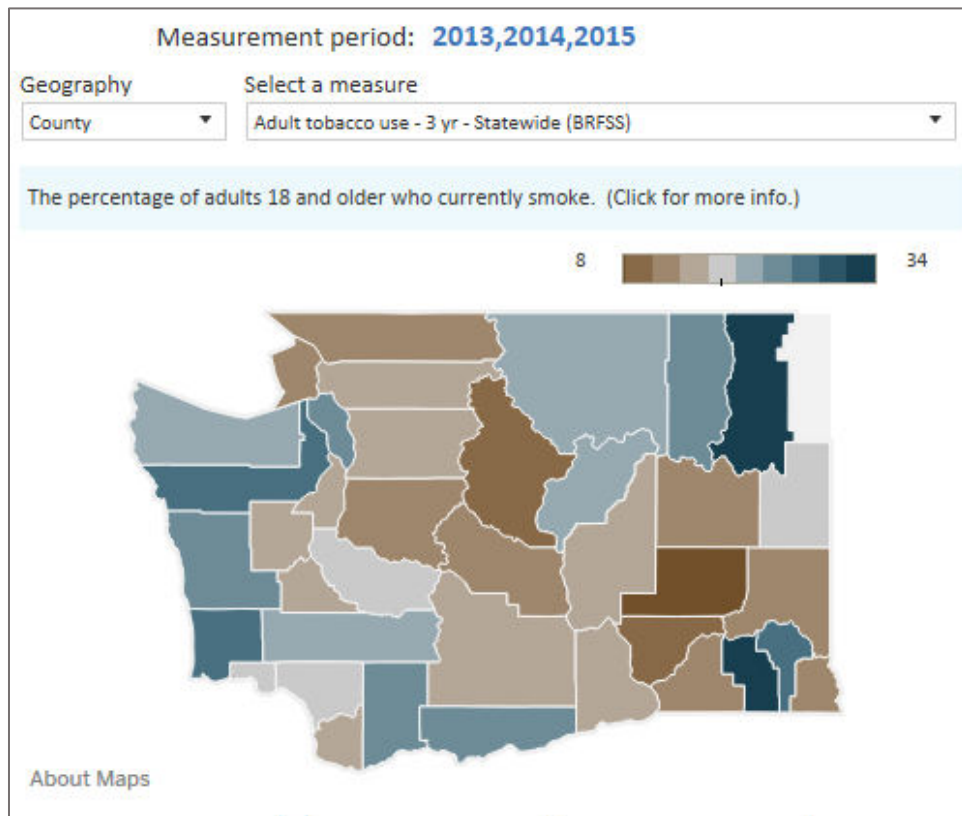
Variation for chronic disease

Overall, estimated chronic disease prevalence among the Medicaid population in BHT ACH is close to the statewide figures: approximately 3% of enrollees had an inpatient or outpatient claim in the last year that included a diagnosis of diabetes (vs. 4% statewide), 5% had a claim with a diagnosis of asthma (vs. 4% statewide) and 11% received a diagnosis of depression.²⁷ However, these figures mask some regional variation:

- Asthma is higher than the state average in Stevens County (6%) and Ferry and Spokane Counties (both 5%).

- Smoking is a risk factor for a number of chronic diseases. BHT ACH has some of the highest (Stevens County at 33%) and lowest (Adams County at 8%) smoking rates among Washington's Medicaid beneficiaries.

Figure 5: Smoking prevalence by county, 2013-15²⁷



- Depression diagnoses among Spokane and Pend Oreille County Medicaid recipients are higher than the Washington average at 12% but Adams County has the lowest rate in the state at 3%.

Chronic disease management for BHT ACH's Medicaid population also varies:²⁸

- Between 83% and 87% of diabetics receive regular blood glucose and kidney function tests, but only about a third receive annual eye exams for retinopathy.
- About 32% of individuals with persistent asthma are on appropriate medication and 26% of those with advanced CVD receive a statin prescription. These relatively low numbers are nevertheless above the state average performance (28% for asthma medication management and 20% for statin therapy).

Existing healthcare providers serving the Medicaid population

The BHT ACH region includes:

- 14 hospitals (not including military or V.A. facilities), 8 of which are critical access hospitals
- Eastern State Psychiatric Hospital
- 13 Rural Health Clinics
- 6 Federally-Qualified Health Centers with a total of 28 locations in the region
- 5 Tribal or Urban Indian Health Program clinics, and an Indian Health Service Clinic in Wellpinit on the Spokane reservation

In addition, there are 34 Mental Health and/or Substance Abuse Disorder service providers contracted with the Regional Behavioral Health Organization, many of whom have multiple clinic locations. See Appendix 10 for a list of healthcare facilities in the region.

BHT ACH's Medicaid beneficiaries are served by five MCOs: Amerigroup Washington, Community Health Plan of Washington, Coordinated Care Washington, Molina Healthcare of Washington, and United Healthcare Community Plan. Molina has the largest share of managed care enrollees overall (47%) but is not the biggest plan in every county. Between 14% and 36% of Medicaid recipients in BHT ACH's region are not enrolled in a managed care plan, depending on the county. Ferry County, where more than a quarter of Medicaid beneficiaries identify as American Indian / Alaska Native and must opt in to MCO enrollment, has the highest proportion of beneficiaries in fee-for-service at 36%.²⁹ This high proportion of FFS clients can make it challenging to coordinate care.

Information about providers' acceptance of Medicaid clients is limited and often not current. Surveys conducted within the last 5 years as part of the Health Professional Shortage Area designation process suggest that the majority of primary care providers in the BHT ACH region serve at least some Medicaid patients and that 65%-75% of dentists do so.³⁰ But anecdotally, BHT staff have received reports of much lower acceptance rates for *new* Medicaid patients among dental providers in particular.

Existing community-based resources available to the Medicaid population

The findings of the 2016 Community Linkages Study³¹ described earlier under *Data Sources* speak directly to the availability of community-based resources for Medicaid beneficiaries:

- BHT ACH's community-based resources most commonly address these needs: community support (socially supportive care and peer groups that foster an individual's sense of support and belonging); education; food (access, affordability, nutrition); housing (access, affordability, and placement); income stability; and transportation.

These kinds of resources are particularly relevant for supporting Medicaid clients with a whole-person care approach.

- A strong majority of responding organizations offered services in Spokane County, particularly among social sector groups. Organizations from the social sector were central to the network in Spokane County (along with the public health department), whereas health and educator sector players were more central in the northeast tri-county region and in Lincoln-Adams counties. This suggests that additional time and effort will be required to link social support systems to health care in BHT ACH's rural counties.
- Most of the reported organizational linkages involved collaboration (e.g. attending meetings together, sharing resources, completing joint projects - 56%) or referral (30%). Data exchange, education, and financial support were much less common (less than 6% of linkages for any of those categories). BHT ACH is taking these findings into consideration as it develops plans to support value-based payment and population health data systems in the region.
- The social sector was the best linked to other sectors (including health) and had the most linkages overall. Health sector organizations were well linked with each other but slightly more siloed within their sector.

BHT ACH will explore the feasibility of repeating the community linkages study in some form in the future as a means of evaluating the impact of the ACH and MTD-supported activities on system connection and integration across sectors.

In addition to the Community Linkages study, BHT ACH's Community Care Coordination Inventory (see description under *Data Sources*) provides data on community-based resources for the Medicaid population. The 27 organizational respondents (including three MCOs) described substantial existing efforts and investments in care coordination and case management, such as a rural Elder Diabetes Project offered by a community-based organization using Stanford Chronic Disease Self-Management model certified educators, or a transitional respite care program in Spokane that provides post-hospital housing, care, and service coordination to homeless individuals.³²

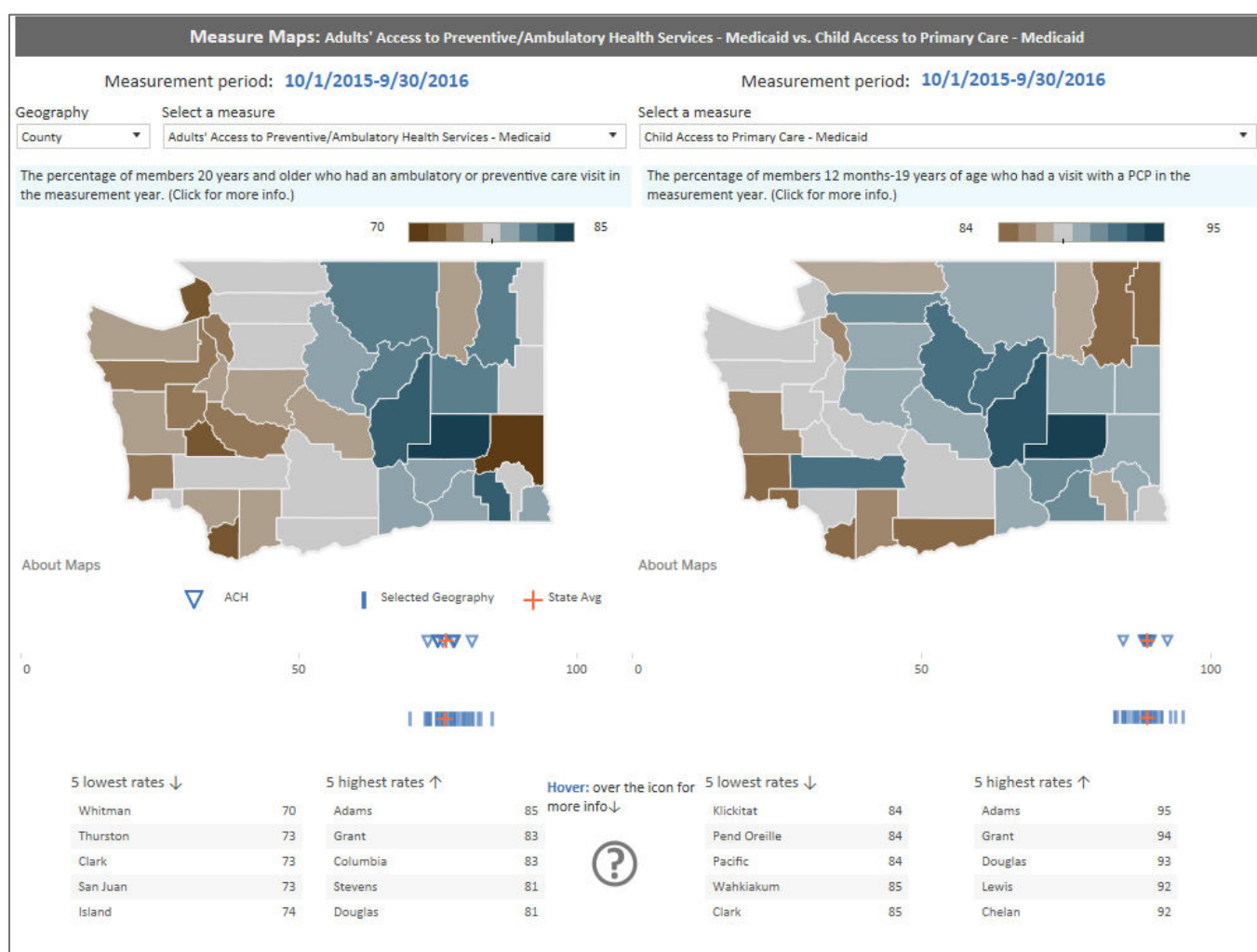
As the operator of the Navigator Network of Eastern Washington, BHT has direct connections with more than 50 organizations who host or employ navigators to help people sign up for coverage through *Washington Healthplanfinder*. The partners represent many sectors including: Community health clinics, hospitals, public health, nonprofit organizations, faith based community organizations, behavioral health providers, the criminal justice system, aging and long-term care, affordable housing agencies, libraries, early learning, K-12 education, and

higher education. BHT ACH is leveraging these connections to engage partners in MTD project planning and implementation.

Access and connection to care for the Medicaid beneficiary population

Access to and utilization of care among Medicaid beneficiaries varies considerably within the BHT ACH's region. Rates of adult use of ambulatory or preventive care are generally at or above the state average in most of BHT's counties but Stevens County is an exception. Among children (1-19 years), primary care visits are below the state average in all three northeastern counties but substantially above the average in Adams County, where children make up 68% of the Medicaid population.³³

Figure 6: Rates of access to primary care among adults (left) and children (right), 2015-16

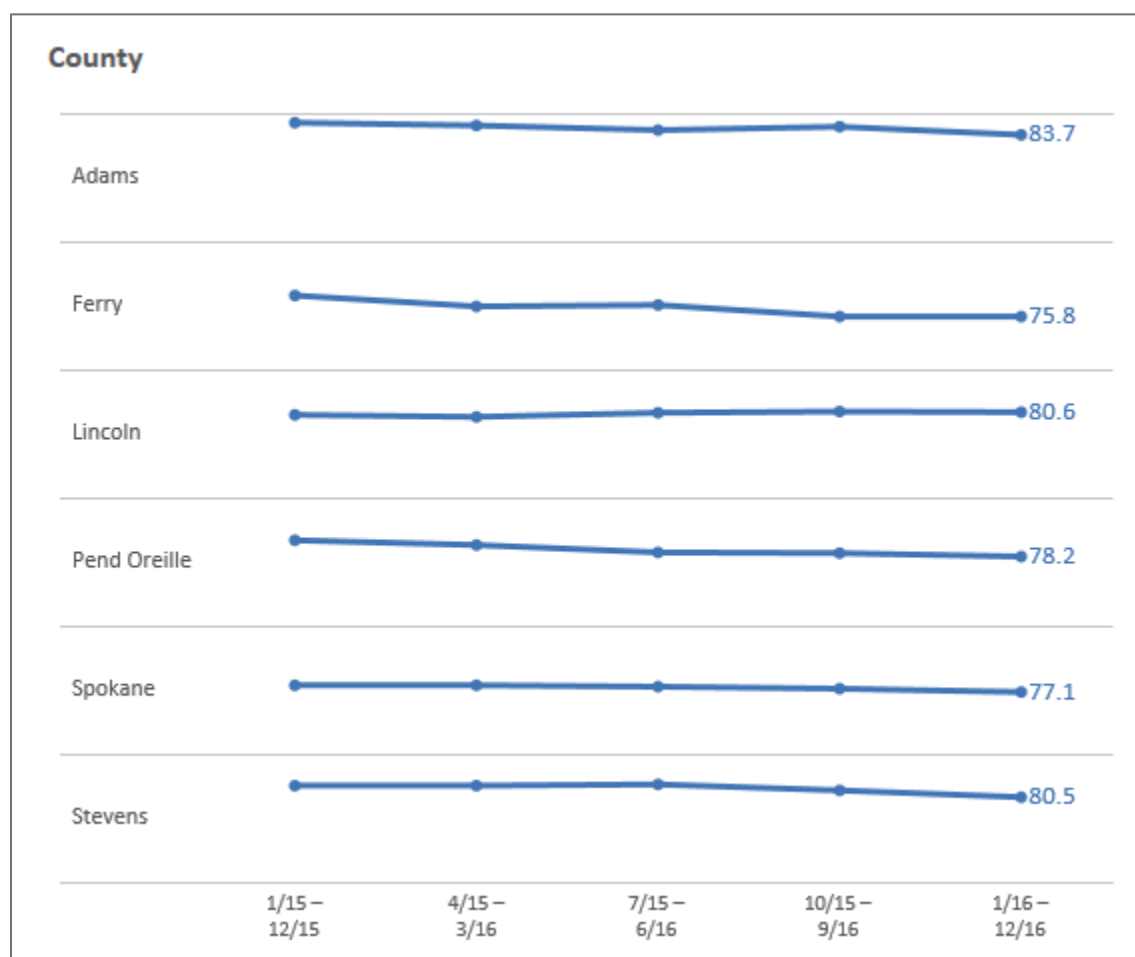


Disparities also exist by gender and race. Only 69% of adult male Medicaid beneficiaries had an ambulatory or preventive care visit in the last year, vs. 85% of women. Among different racial groups, rates of ambulatory or preventive visits by adults in the last year ranged from a low of

72% among Native Hawaiians and Pacific Islanders to a high of 80% among AI/ANs and individuals who identified as multi-racial.³⁴

Qualis Health reports that all MCOs in Washington state showed decreases in adult access to ambulatory/preventive health services from the 2015 to 2016 reporting years and that the state rate is now more than 5 percent lower than the national average for Medicaid plans.³⁵ In the BHT ACH counties, rates have declined most noticeably in Ferry, Pend Oreille, and Stevens Counties.

Figure 7: Medicaid adults (20+) who had an ambulatory or preventive care visit in the measurement year (rolling 12-month periods)³⁶



Variation is also the story for access to and utilization of particular forms of care:

- ED utilization (broadly defined, including visits related to mental health or substance abuse issues) is currently at 70 visits per 1,000 member months for the BHT region, which is slightly above the state average of 68 visits per 1,000 mm. But the aggregate BHT ACH figure is driven by the population concentration in Spokane County; adult

Medicaid-covered residents of Adams, Lincoln, and Ferry counties have some of the lowest Medicaid ED utilization rates in the state.³⁷

- BHT ACH is a little below the state average for mental health treatment and substance abuse treatment penetration rates among Medicaid beneficiaries. On the other hand, rates of follow-up after a hospitalization or ED visit related to mental health or substance use are higher than the average for Washington state Medicaid.³⁸

Gaps between Medicaid population needs and available services

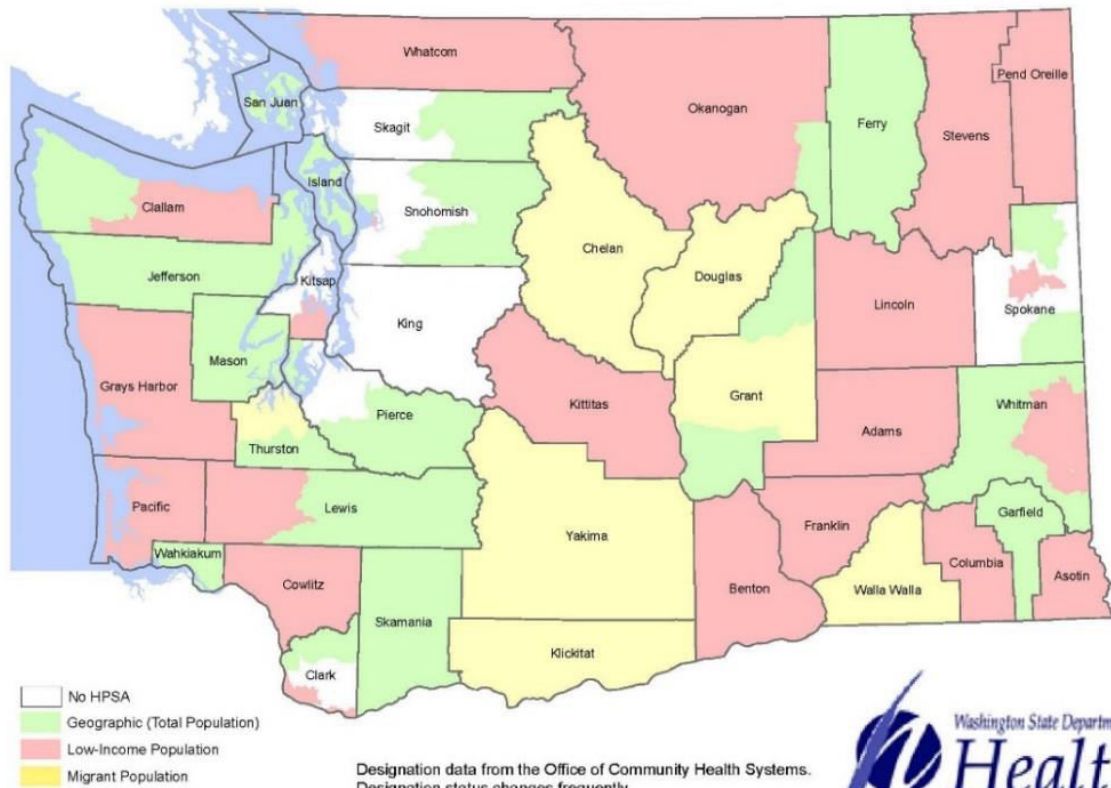
BHT ACH's region is geographically spacious, covering 12,273 square miles. The area includes Washington State's highest-elevation, paved road at 5,574 feet (Sherman Pass) and only one interstate highway, meaning that State Routes, rural roads, and ferry crossings are the primary routes of travel. Transportation shortcomings, geographic barriers, and inclement weather frequently limit access to care.

Most of BHT ACH's region, other than the Spokane metro area, has multiple health professional shortage area (HPSA) designations:³⁹

- There is a shortage of primary care professionals for *all* residents of Ferry County (green shading in the map below), and for low-income residents in most other areas of BHT (pink shading)

Figure 8: Washington Primary Care Health Professional Shortage Areas, Jan. 2017

Federally Designated Health Professional Shortage Areas for Primary Care January 3, 2017

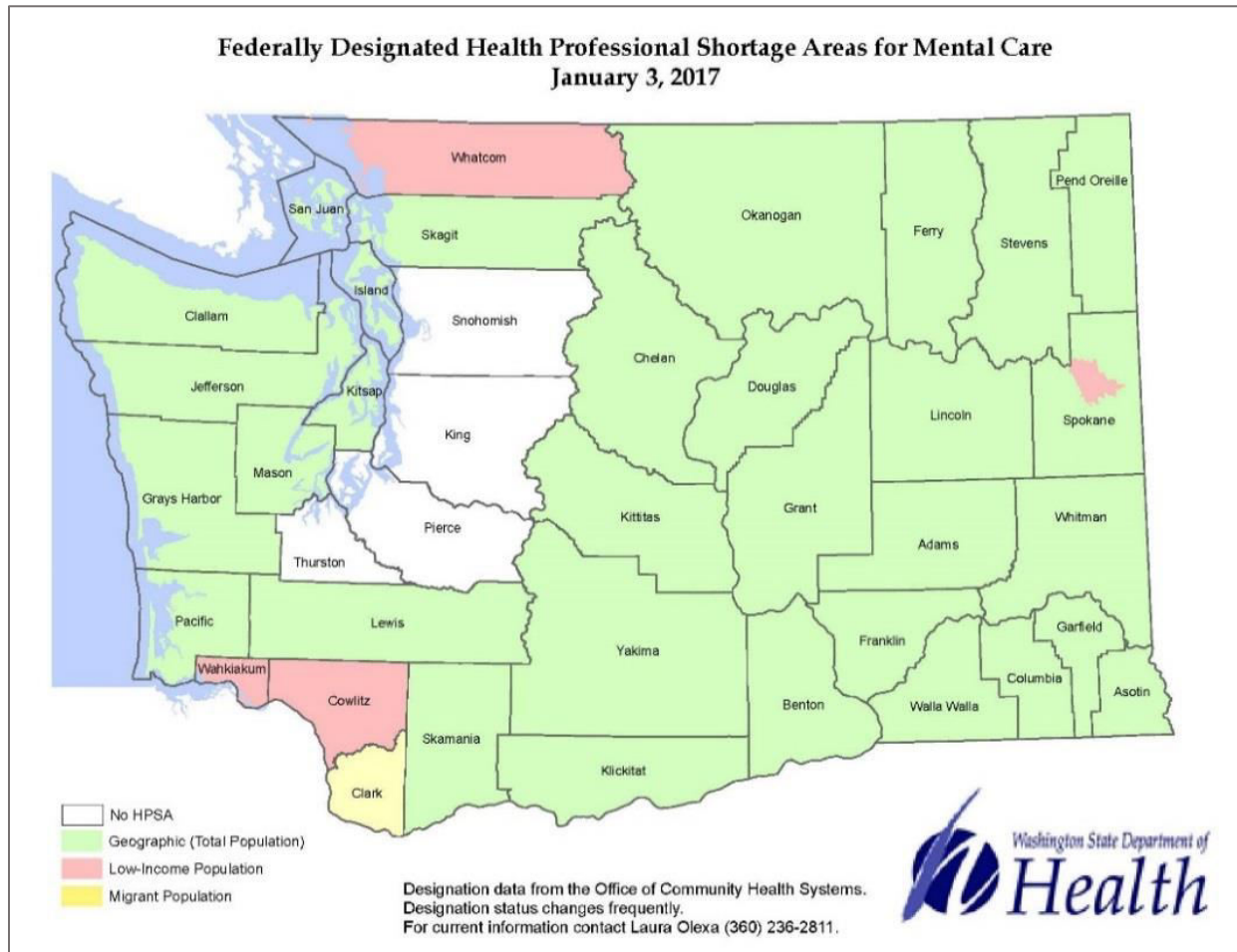


Designation data from the Office of Community Health Systems.
Designation status changes frequently.
For current information contact Laura Olexa (360) 236-2811.



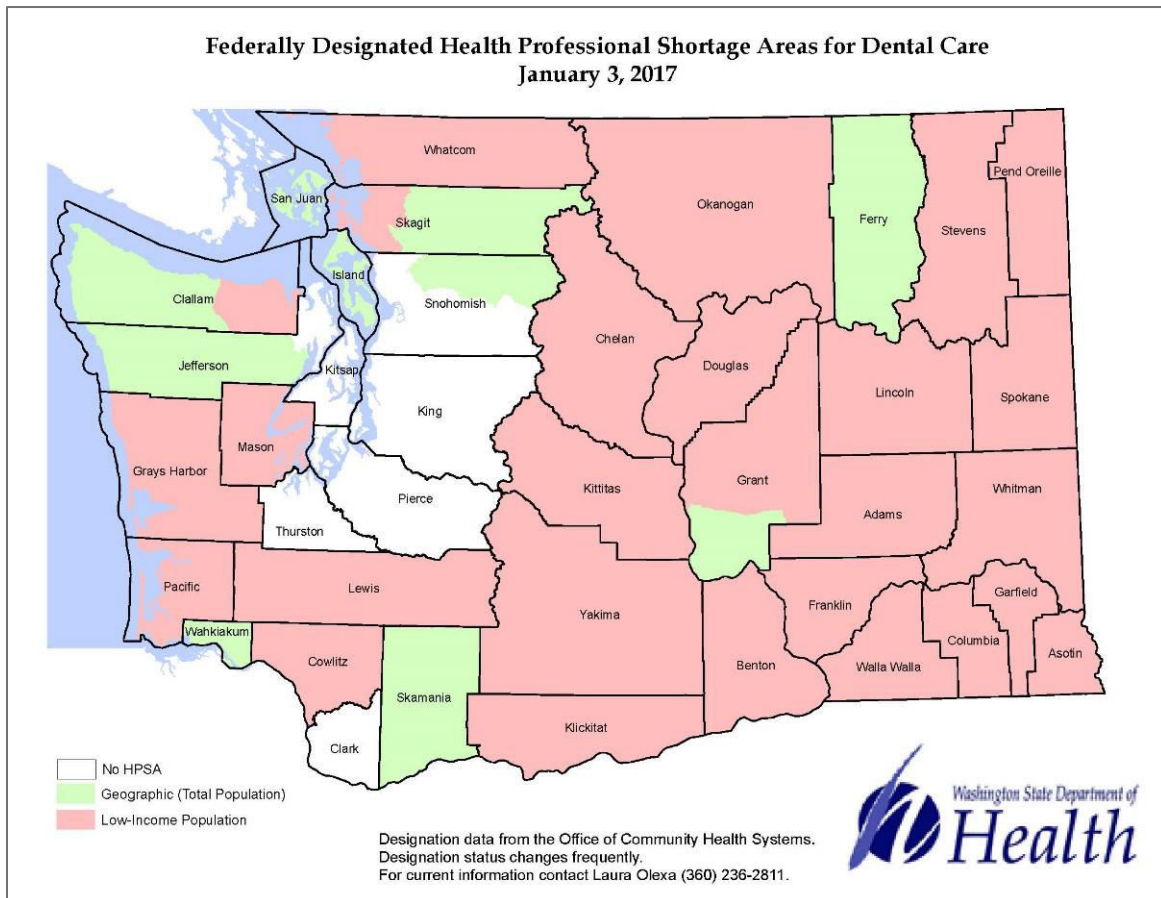
- All BHT ACH counties have a shortage of mental health providers for any resident, including most of Spokane County (green shading). The metro Spokane region is designated as a low-income mental health HPSA (pink shading).

Figure 9: Washington Mental Health Professional Shortage Areas, Jan. 2017



- Finally, all BHT ACH is designated as a dental health care professional shortage area. The designation applies mostly to low-income residents but applies to *all* residents of Ferry County (green shading in the map below).

Figure 10: Washington Dental Health Professional Shortage Areas, Jan. 2017



The University of Washington's Center for Health Workforce Studies reports that Eastern Washington has fewer physicians providing direct patient care than the Western part of the state (185 per 100,000 population vs. 242 per 100,000) and that the physician workforce is growing more slowly in the east. The east-west physician supply disparity is even more pronounced for psychiatrists: in 2014 there were 4.9 psychiatrists per 100,000 in counties east of the Cascades vs. 11.9 per 100,000 in western counties. Eastern counties *lost* 2.5% of their psychiatrist workforce between 2014 and 2016, whereas Western Counties saw a 9% increase.⁴⁰ BHT ACH area participants in the Washington State Health Workforce Sentinel Network report recent increases in demand for clinical social workers and mental health counselors.⁴¹

Statewide in 2016, 77% of adult Apple Health enrollees reported that they were usually or always able to get needed care and 78% reported usually or always getting care quickly. Regional results are not available and there was little variation among the MCOs.⁴² BHT ACH has lower-than average (for Washington state) rates of potentially avoidable ED visits among Medicaid beneficiaries⁴³ and, except for the Spokane metro area, lower than average rates of potentially avoidable hospitalizations (all payers).⁴⁴

In the interests of reducing access shortcomings, provider partners in the BHT ACH region have a strong interest in expanding telehealth capacity. Telehealth priorities reported by respondents to BHT ACH's Health Systems Inventory included psychiatry, neurology, and remote monitoring.⁴⁵ Conversations with provider partners have illuminated a few barriers to expansion of telemedicine services that BHT ACH will explore further as part of MTD project planning. These include certification requirements that require a larger encounter volume than some rural providers have, the cost of technology and space for telehealth-enabled visits, and staff training.

ACH Theory of Action and Alignment Strategy

Better Health Together Vision

Better Health Together's vision is that every person, regardless of background, life experience or environment, will live a productive, high quality life, with access to stable housing, nutritious food, transportation, education, meaningful employment that pays the bills with some left over for savings, and social support networks that foster emotional and psychological wellbeing. Please see Attachment 1 for an updated Theory of Action logic model graphic. This is a lofty vision and will not be achieved by any one organization. Better Health Together (BHT) will achieve this vision by developing an integrated community health system, accountable to improving health through delivering culturally competent, whole-person care to each person within the region.

While BHT ACH's vision is aspirational, our work is grounded in the needs and concerns voiced by our extensive array of partnering providers as well as the regional health priorities identified through our regional health needs inventory. Spanning 12,273 square miles, much of our region consists of isolated, rural communities that are miles away from consistently available health services. Provider shortages, especially in behavioral and oral health, further constrict access, especially for rural health providers who struggle to fill positions. Severe disparities exist even in resource-heavy urban center Spokane, where the life expectancy between neighborhoods varies by up to 18 years.⁴⁶

Our jail and emergency systems are over and inappropriately utilized by behavioral health patients without access to stable social and health supports. Youth in Spokane County enter foster care at nearly double the state average.⁴⁷ A severe housing shortage further increases the risk of homelessness for vulnerable people. These social risk factors may contribute to our high prevalence rates of asthma among youth (self-reported at 14-24%)⁴⁸ and diabetes in adults (ranging from 9-14% in the BHT ACH counties).⁴⁹

The BHT ACH conducted Health System and Community Care Coordination Inventories, which surveyed partners for their vision, capacity, engagement of clinicians and patients, workforce, and data needs for Medicaid transformation. Based on information obtained through these inventories coupled with regional health needs, the BHT ACH identified the following actionable goals:

- Improve whole person care in quality and access through the integration of behavioral, physical and oral health systems

- Develop strong community systems that link housing, food security, transportation and income stability
- Decrease obesity rates across all populations through prevention
- Scale community-based care coordination to improve health

These four regional priorities speak to a community desire to see stronger linkages between health and social determinants systems to support whole-person, community-based care with a focus on prevention. BHT ACH's extensive community conversations, along with provider surveys and data assessments, also identified priority populations for the region. Beneficiaries with complex care needs, particularly those with a co-occurring behavioral health disorder and chronic disease — such as diabetes, asthma, hypertension, and cardiovascular disease — have been consistently identified as high-priority populations for the region. The needs of these priority populations will be emphasized throughout the Project Portfolio and through BHT ACH's additional investments, strategies and partnership activities.

By emphasizing the needs of these populations through the Project Portfolio and other activities, the BHT ACH expects to lower costs and improve health care delivery and outcomes for the region's most vulnerable populations as well as improve the overall health system. BHT believes that a truly effective community health system not only cares for the whole person, but is accessible and used by all. We know from experience that the best solutions are led locally and help build a stronger bridge between clinical and community providers. A daily mantra for BHT staff and partnering providers is "success will require EACH of us to be bold and engaged." Despite the high level of engagement of regional providers in the BHT ACH vision and plans, changing practice and payment models will be challenging. The Medicaid Transformation Demonstration (MTD) funds will enable the BHT ACH to jump-start the needed transformations, prove the sustainability of its projects, and support practice changes across provider settings.

Project Portfolio

The BHT Board of Directors' decision about project selection was based on recommendations from our Waiver Finance Workgroup and BHT staff, presented at the November 2nd, 2017 meeting. The Board approved a Project Portfolio that includes four projects:

- Bi-Directional Integration of Care (required)
- Community-Based Care Coordination
- Addressing the Opioids Use Crisis (required)
- Chronic Disease Prevention and Control

The BHT Board selected these four projects because of their importance to Medicaid beneficiaries in the region as well as the regional health needs of the broader population.

Although the Board had previously considered a portfolio of six projects, the recent announcement of a reduction in available funds for ACHs prompted the Board to strategically focus the Project Portfolio on the most critical areas of need for long-term health systems transformation.

Project Selection Process

Prior to the portfolio selection in early November, the BHT Board undertook a deliberative process to understand the projects in the MTD Toolkit, their requirements, including the required performance metrics and funds flow weighting, along with community interest and regional needs. This work began in earnest in January 2017 at the annual Board Retreat, during which board members learned further detail about the eight potential projects areas and held early discussions on the prioritization of project areas and the appropriate size of the Project Portfolio. Although board members expressed support for all project areas, there was consensus that the BHT ACH Project Portfolio should be aligned and focused on regional needs and priorities in order to maximize impact. Board members agreed the Portfolio should consist of a minimum of six projects (the minimum number required at the time to be eligible for 100% of the region's potential funding).

In the months that followed, the BHT ACH undertook an extensive community and stakeholder process to develop a Project Portfolio in partnership with providers and based on regional priorities and needs. Community conversations have driven this work since the beginning through Community Strategy Map focus groups, our Leadership Council, and work through five rural county health coalitions and Spokane-based partnering providers for exploring and guiding the best local solutions and early development of the BHT ACH Project Portfolio.

In March 2017, the BHT ACH requested Letters of Interest (LOIs) to more formally gauge interest in each of the eight potential project areas among partnering providers and community stakeholders. There was cross-sector representation in the project selection process, including community health and behavioral health centers, managed care plans, hospitals, community partners, consumer perspectives and community-based organizations. This initial process identified community interest in all eight areas. Further community conversations with partnering providers (including provider focus group sessions), meetings with the Tribal Partners Leadership Council, and in the BHT ACH Leadership Council meetings resulted in the prioritization of six project areas for the region: community-based care coordination, bi-directional integration, addressing the opioid crisis, chronic disease, as well as transitions of care and diversions.

In summer 2017, the BHT ACH then conducted Health Systems and Care Coordination inventories with key agencies across all six counties in the region. This process revealed that interest and tangible priorities were most concentrated in:

- Community-based care coordination
- Integration of care, including behavioral health, physical health and oral health
- Addressing the opioid crisis
- Chronic Disease

Overwhelmingly, community-based care coordination was identified as the highest priority in the region. As a result, the Pathways Hub model for community-based care coordination will serve as an anchor strategy due to the centrally identified need to “coordinate the coordinators,” which has been identified over and over again when engaging with community partners.

With the community prioritization process and Health System and Care Coordination Inventories in mind, along with health data from the Regional Health Needs Inventory and other sources, the BHT ACH Technical Councils including the Waiver Finance Workgroup and the Tribal Partners Leadership Council, as well as the ACH Leadership Council and Board of Directors more deeply considered the models in the toolkit and the required performance metrics. The need to prioritize and focus was again reinforced by the Board, with an emphasis on building upon work already underway and capitalizing on the priorities and interests of the region’s health systems. The Board considered the balance of partnering providers’ interest in focusing the portfolio, particularly given the significant cuts in the DY2 budget announced in late September, with broader community stakeholder interest in an expanded portfolio. The BHT ACH made a conscious decision to use the Project Portfolio as a primary lever for increasing the region’s readiness for Value Based Payment (VBP). Ultimately, the Board determined that the four project areas with the strongest responses in the health inventory were the right Project Portfolio for the BHT ACH region and would build the best foundation for investing in VBP readiness and incorporating the social determinants of health. However, because of the commitment to all eight areas in the toolkit, the Board has also directed the BHT ACH to incorporate oral health, transitional care, diversions, and reproductive, maternal and child health into ACH activities and strategies.

Project Selection Criteria

The BHT ACH used the following principles to guide its decision-making process around the Project Portfolio:

- **Regional Need:** Does it connect to a high magnitude of documented need (without duplication or intense competition of existing efforts)?
- **Health equity:** Does the strategy reduce health disparities and/or advance health equity? Does it address/support social determinants (underlying community conditions)? Does it reduce stigma and discrimination?

- **Impact & Sustainability:** Can/does it affect a large number of Medicaid-covered lives and will it provide a return on investment within 2-3 years?
- **Feasibility:** Is there partnering provider interest? Do the strategies or activities build on (and not duplicate) existing efforts? Is there a clear role for the ACH? Does the strategy link to P4R and P4P measures in the toolkit?
- **VBP Readiness:** Will it increase regional readiness for VBP by the end of the demonstration?

Shared Interventions, Resources, and Infrastructure

All of the projects in the BHT ACH Project Portfolio make use of the Pathways HUB as a shared resource. Along with integration of care, expanding care coordination efforts will be an anchor strategy for the BHT ACH region in connecting disparate systems. The BHT Pathways Hub will support best practice care coordination and information sharing across the region's community-based organizations and health systems. The Pathways technology platform provides real-time data to identify resource gaps and monitors the effectiveness of best practice interventions as well as the quality of the care coordination agencies implementing them. This will be a powerful tool to support a data-driven case for alignment of community investments, especially around major resource gaps in safe and affordable housing, jobs in rural counties, and transportation throughout the region.

The BHT ACH will withhold 10% of all demonstration dollars to invest in a Community Resiliency Fund. The fund will align with ACH community priorities to strengthen the linkages between the health care systems and providers who focus on social determinants of health. It is the intent of the BHT ACH to leverage these dollars to influence increased, targeted investment in population and community health improvement, including aligning nonprofit hospital community benefit dollars, philanthropic funders, and shared savings investment models based on data supported by a BHT ACH Community Dashboard (explained below).

All our projects will share an emphasis on disrupting the intergenerational cycle of Adverse Childhood Experiences (ACEs), a central part of whole person care for our region. ACEs will be incorporated into each project's implementation plans. Many concurrent regional activities are addressing these risk factors, including multisector organizations such as Priority Spokane, Invest Health, the A Way Home Washington 100 Day Challenge around ending youth homelessness, and Empire Health Foundation's region-wide ACEs initiative. The BHT ACH has actively engaged in design efforts with these partners to ensure proactive connection to MTD projects and, specifically, care coordination efforts.

In addition, the BHT ACH is developing a shared learning and quality improvement infrastructure. This infrastructure will include the **BHT Provider Champions Council**. This

recently established council will provide general clinical and subject matter expertise across the four MTD project areas. The council will monitor trends in clinical performance across the projects to assess whether the BHT ACH is on track to achieve expected outcomes and will advise on proposed risk mitigation and continuous improvement strategies. The BHT ACH's **Director of Clinical Integration**, a position currently in recruitment, will staff the Provider Champions Council and help identify, communicate, and address challenges to clinical integration and other transformation strategies.

To serve as the implementation arm for the MTD Projects, the BHT ACH will utilize a **Community Health Transformation Collaborative** model, with a Spokane County based Collaborative and a Rural Collaborative, including each of our five rural counties. Collaboratives will be supported by BHT staff, who will have a "bird's eye view" of work occurring across the region. The Collaboratives will be comprised of key partners with the expertise and experience required to transform our Medicaid Delivery System including clinics, Federally Qualified Health Centers (FQHCs), hospitals, mental health and substance use providers, EMS, Jails and County Commissioners. Each Collaborative will be accountable to develop a county-based system of care project plan to meet both the regional ACH objectives and the MTD project requirements. In addition to developing a county-based plan, the Collaboratives will be accountable to monitor performance, course correct when necessary, and participate in shared learning opportunities within the region.

BHT ACH is contracting with the Providence Center for Outcomes Research and Education (CORE) to lead the monitoring system design and oversight. Providence CORE will serve as a shared resource across projects, coordinating with BHT staff and the entities above to provide timely information, data interpretation expertise, and both technical and strategic support for peer learning and continuous improvement. We expect CORE to develop a community dashboard to monitor key metrics identified in the MTD Toolkit and our community priorities. This will be a multi-functional dashboard extending beyond the MTD to allow ongoing community tracking and priority setting.

Statewide transformation efforts outside Medicaid will also serve as a shared resource and framework for the BHT ACH Project Portfolio. There are a number of statewide, system-level activities in motion which are driving efforts for transformation, including the shift to value-based payment (VBP) by 2021, the shift to Fully Integrated Managed Care (FIMC) by 2020, and efforts which are aligning Medicaid and Medicare payment structures. To be successful under this transformation, providers must develop new practices and workflows that will meet specified outcomes. The BHT ACH views whole-person care as a fundamental element for success in a value-based care system. If the system is not equipped to see and respond to whole-person needs of patients, true population health improvement will never be possible. Aligning regional energy and investment in activities that support whole-person care will help prepare our region for success.

Concurrent to these activities, MTD dollars create an opportunity to accelerate some of the transformative changes, while demonstrating the value of whole person care for patients and the overall efficiency of the system. Over the next five years, the BHT ACH will coordinate the four intersecting projects that target high-needs Medicaid patients and build out multi-sector linkages between providers that support whole person care (see logic model in Attachment 1). Each of these projects will be tied to specific outcome measures that will incentivize providers to develop new processes to drive patient health improvement.

The BHT ACH seeks to maximize regional efforts by aligning MTD projects with implementation strategies developed for upcoming Medicare changes via providers' participation in an ACO and/or MACRA/MIPS preparation. Over the last three months, the BHT ACH has explored ways to leverage rural participation in an ACO to create more opportunity for investment and earnings for counties with high rates of both Medicaid and Medicare. These aligned efforts will build community infrastructure and scale up best practice that supports responsive and sustainable systems improvement. With these new linkages and practices in place, the BHT region will be poised for large scale improvement of population health.

Region-Wide Improvements

The BHT ACH made a strategic decision to focus its Project Portfolio on the four critical areas necessary to improve region-wide health outcomes as well as the quality, efficiency and effectiveness of the care delivery system. Overwhelmingly, providers and community partners see Community-Based Care Coordination as a foundational investment critical to health systems transformation. Increased care coordination; whether through Community Health Workers, Care Coordinators, or Peer Support Specialists will create stronger and better connections and resourcing of social supports that will improve outcomes for Medicaid beneficiaries and accelerate additional delivery system changes that will ultimately benefit all consumers. Investments and activities to support integration of care, including physical, behavioral and oral health care, will improve providers' ability to coordinate care for all patients and help to build capacity necessary for new payment models. Additionally, Chronic Disease is a significant cost driver in the region's health care system, for Medicaid beneficiaries and all consumers. Strengthening the region's ability to prevent chronic disease and provide better management for those living with chronic disease will improve outcomes and lower costs, freeing up much needed resources within the health care delivery system. And finally, the Opioid crisis impacts every community and every income level. It undermines efforts underway to improve quality of care and lower costs. Addressing this crisis through education, overdose prevention, treatment and support for recovery, is necessary to prevent the issue from continuing to worsen.

Health Equity

Health equity is a foundational goal of the BHT ACH Project Portfolio. To ensure that individuals facing the greatest health disparities are served by our efforts, all of the projects will engage in extensive assessment of target populations by race/ethnicity and language as well as geography during the planning phase. In order to address health equity, the system needs to be supported by mechanisms and practices which allow providers to recognize the holistic needs of the patient. We see positive movement in this direction with the recognition of the degree of disparity that exists in the community and an ever-growing acceptance of the impacts of social determinants on overall health status. It is the intent of the BHT ACH to continue to work to address environmental and community barriers to improving population health. At the core of health system transformation effective links between the health care system and the social determinant of health.

The BHT ACH has devised a few key activities to accelerate our own equity work, including:

- **Disaggregating data by race/age/ethnicity/sex/zip code wherever possible both to make informed decisions about target populations and to monitor impact of projects across diverse groups.** The BHT Board has identified impacted populations to target for MTD projects. BHT will supply Collaboratives with regional data to guide assessments of partners, and expect to direct teams to develop Transformation plans to address populations within their county that face a high level of disparities and/or present as highly complex or high risk.
- **Launching a Community Voices Council, made up of at least 50% Medicaid beneficiaries or low-income community members, as well as Community Advocates and people with experience working in Medicaid services.** This council will be tasked with developing Health Equity metrics to which the Collaboratives will be accountable for health equity goals and standards. This Council will review the Collaboratives' Health Equity and Transformation project plans and provide feedback on effectiveness to addressing access to care and equity.
- **Developing an "Equity Accelerator Payment" for providing partners who serve a greater proportion of high risk clients.** This may include organizations that serve predominately Latino/ Hispanic, Native or African American populations – all of whom experience significant health disparities– or organizations providing specialty services to highly complex patients that require more intensive care, such as some smaller Mental Health and SUD providers who might be seeing fewer patients because the ones they serve have such intense needs. (We expect the metrics tied to these payments will be explored by the Waiver Finance Workgroup, vetted by Provider Champions Council and Community Voices Council, and then finalized for BHT Board approval.)
- **Furthermore, the strong emphasis on Community-Based Care Coordination as an anchor strategy serving all projects in the Portfolio will also enable the BHT ACH to promote health equity.** The Pathways Hub model will expand access to CHWs and the

region, providing culturally and linguistically responsive care across all of the projects. The Pathways Hub closely monitors the progress of each Care Coordination Agency's Care Coordinators and clients to look for trends, strengths, and weaknesses among providers. This both helps the Hub to maintain the quality of care, and offer trainings when weaknesses are identified, and helps the Hub grow our understanding of which agencies may offer the greatest expertise or experience with specific populations. Additionally, the Pathways model is often most successful when implemented with care coordinators who have lived experience and/or can relate to patients they are serving, providing an opportunity for workforce development and service delivery.

The BHT ACH also intends to connect project work, particularly in the Chronic Disease and Community-based Care Coordination project, to larger systemic work to affect ACEs. Having one or more ACEs is associated with higher incidence of chronic illness.⁵⁰ Our focus on a population with disproportionate impact of chronic illness is one way to help disproportionately affected populations more generally.

Business Model and Sustainability

The BHT ACH is focused on moving the region to VBP and whole person care. VBP is the cornerstone of our sustainability plan in recognition of the need to transition how we pay for care and linking services that address social determinants of health. We are working to align data, funds flow, and model development to maximize the opportunity to integrate selected projects into a value-based model and weave together local resources and investment to reach this goal. For instance, our Funds Flow policy will include directed investments for startup costs as well as infrastructure and technical assistance emphasizing DSRIP funding for transition, not an ongoing payment stream.

The Community Health Transformation Collaboratives are designed to support the formation of the partnerships needed to support geographically based systems of care in a value-based environment. The linkages created to support the MTD projects will translate to the relationships necessary to succeed in a value-based model and improve population health. The support from the ACH, MTD dollars, and local investment will create an environment to test new processes and implement new practices to ensure readiness for VBP and improved care delivery.

Each of the four MTD projects play a key role in infrastructure change needed to support VBP. Increased focus and investment in prevention, and scaling more efficient and connected intervention strategies, will lead to a more responsive community health system. The BHT ACH is also working to align its strategies with the ACO developments in Medicare, especially in rural counties with the most recent meeting with partners on November 3rd, 2017 in collaboration with Greater Columbia and North Central ACHs.

The Community Resiliency Fund is an area that may extend beyond the MTD period as we build community investment to support effective approaches to addressing social determinants of health. BHT will develop a community dashboard that monitors key social determinant and health indicators of our regional health system's viability. By aligning regional partners and investors around these indicators, using the demonstration as a catalyst, we can identify synergies and create a leveraged fund of flexible dollars for the region to access for strategic investment in overcoming health disparities.

Improvements since Phase II Certification

Since Phase II Certification, the BHT ACH has developed concrete plans for shared resources across project areas. The BHT ACH has continued to refine its plans for supporting the work of the MTD Projects, as well as the long-term role of the ACH. As the regional Pathways Hub, the ACH will maintain a network of community-based referrals and care coordination resources, ensuring best-fit care at the right time. The ACH will track population health across multiple systems to measure the overall effectiveness of the care network in improving access and outcomes. Baseline data will define the current status and help identify bright spot interventions to scale as well as gaps or widening health disparities. This data will inform recommendations for policy change. Committed to furthering our work past DSRIP, the BHT ACH will position the use of the Pathways Hub and a Community Dashboard as long-term community infrastructure.

Governance

BHT's Governance Structure

Although the Board of Directors is ultimately accountable for Better Health Together ACH decisions, our governance structure is multi-tiered with distributed decision-making, joint ownership and mutual accountability that drives innovation and fosters co-investment that leads to impact. This structure is comprised of the following bodies (see also the Governance structure chart in Attachment 2):

- **Board of Directors:** 19-member decision-making and oversight body for BHT ACH. Accountable for Transformation Projects and all work of the Better Health Together ACH. There are four standing operating committees of the Board to conduct work of the Board and prepare the Board for decision-making. These are:
 - **Executive Committee:** Committee with the authority to make decisions on behalf of the Board as appropriate and conduct other Board business.
 - **Governance Committee:** Recommends for approval Board Candidates, Officers, Committee Leadership and members.
 - **Finance Committee:** Provides financial oversight for ACH administration, BHT budget development, and other BHT financial operations.
 - **Audit Committee:** Annually reviews Audit findings from independent auditors.
- **Leadership Council:** An advisory body currently comprised of 68 organizations, whose broad participation helps synthesize local priorities into regional strategies. See Appendix 11 for the most recent list of Leadership Council members). It is expected that the Leadership Council will be convened on a quarterly basis in 2018.
- **Tribal Partners Leadership Council:** To foster collaboration and communication with regional Tribes, Indian Health Service facilities, Tribal Organizations, and Urban Indian Health Programs, The Tribal Partners Leadership Council was chartered and is comprised of representatives from the Kalispel Tribe of Indians, Confederated Tribes of the Colville Reservation, Spokane Tribe of Indians, The NATIVE Project, The Healing Lodge of the Seven Nations, and the American Indian Community Center. Recognizing the unique and important role that American Indian/Alaska Native (AI/AN) populations have in our region, the BHT Board developed this group to ensure that Medicaid Transformation Demonstration (MTD) projects were aligned and culturally appropriate to meet the health needs of Native Americans. This Council will continue to play a critical role in implementation planning and monitoring impact of MTD projects on Tribes, Urban

Indians, and Indian Health Services facilities. The Tribal Partners Council will advise on metrics to evaluate how well project plans address health equity as it relates to AI/AN health.

- **Technical Advisory Councils:** The Technical Advisory Councils provide technical expertise and input directly to the Board of Directors about the region's MTD projects and strategies. There are three Technical Advisory Councils:
 - **Provider Champions Council (PCC):** This recently established Council provides clinical expertise and subject matter support in the development of the "Transformation Compact" (see Program Management & Strategy Development below) across the MTD Projects areas. PCC membership consists of mostly current practitioners within their respective health care settings, including primary care, behavioral health, public health, and emergency medical services. The Council will recommend key clinical elements and performance measures across projects to assess whether Collaboratives are on track to achieve expected outcomes. It is expected that this Council will also play a role in developing clinically-focused continuous improvement strategies.
 - **Community Voices Council (CVC):** The CVC will launch in December 2017. At least 50% of members will be Medicaid beneficiaries, with the other half made up of Community advocates with lived experience helping complex patients access and navigate community services. This group will inform Collaborative project planning by validating implementation plans against the needs and expectations of Medicaid patients. The CVC will advise on metrics to evaluate how well project plans address health equity, and will use these metrics to monitor and make recommendations for course correction as needed. Members will receive a stipend from BHT for their participation.
 - **Waiver Finance Work Group:** This group develops and recommends to the BHT Board a set of policies to govern the MTD Funds and provides oversight of MTD fund distribution as necessary. This team will also validate financial plans for approval by the BHT Board. This group makes recommendations directly to the Board (not to the BHT Board Finance Committee) on all MTD funds allocations and budget, Community Resilience funds, and mid-adopter FIMC Incentives.

For the MTD projects to be successful, BHT recognizes that the ACH leadership must develop and maintain strong lines of communication and collaboration with partnering providers. In addition to the leadership and advisory councils, BHT is establishing **Regional Community Health Transformation Collaboratives:**

- **Rural Collaborative** (including Ferry, Stevens, Pend Oreille, Lincoln, Adams counties)
- **Spokane Collaborative** (Spokane county)

It is the intent of the BHT ACH to take a regional approach to MTD project design and implementation to allow local autonomy while creating regional accountability. The Collaboratives will be responsible for developing and leading actionable MTD plans across BHT's project portfolio, and ensuring that the projects coordinate with and do not duplicate existing efforts in the region. The Collaboratives will be comprised of key partners with the expertise and experience required to transform our Medicaid Delivery System including clinics, Federally Qualified Health Centers (FQHCs), hospitals, mental health and substance use providers, Tribal health systems, EMS, jails and County Commissioners.

The Collaboratives and the ACH Technical Councils will work in a bi-directional feedback partnership to finalize policy and project plans. By design, there is cross-representation between Collaboratives and Technical Councils to ensure local buy-in and regional accountability. It will be the responsibility of these leaders to provide strategic guidance on issues critical to improving health based on experience, expertise, and perspective, using an evidence-based, "health in all policies" approach at both levels.

This structure is designed to promote meaningful, cross-sector collaboration and deep engagement of partners, as well as to prevent any single entity, sector, or person from dominating the decision-making or activities of the ACH. The Leadership Council and the Technical Councils provide the Board with input and recommendations from subject matter experts while the Rural and Spokane Community Health Transformation Collaboratives will provide local control, expertise, and implementation, a critical function for BHT given our large geographic region. Board members participate throughout the Technical Councils and Regional Collaboratives as vested partners and to ensure the Board of Directors has a direct relationship and strong lines of communication.

The following figure demonstrates the integrated and inter-dependent governance structure that connects the BHT Board and Accountable Community of Health Leadership Council to our engagement partners in the Regional Health Transformation Collaboratives. The figure also emphasizes the importance of a common agenda, continuous communications, and mutually reinforcing activities. While the approval of the ACH activities and policies is ultimately the responsibility of the BHT Board of Directors, it is the expectation that the ACH Leadership Council and Community Health Transformation Collaboratives will play a significant role in influencing the development of our region's health transformation plans.

Figure 11: BHT ACH Governance and Engagement Structure



In addition to the groups described above, BHT has established a **Regional Integration Team** to support the state mandated 2020 goal of Integrated Medicaid Managed Care. This team provides a multisector forum for key stakeholders and partners to develop a plan and timeline to meet the state goal and accelerate transformation for the Medicaid population.

Financial Oversight

The **BHT Board Finance Committee** provides financial oversight for ACH administration, BHT budget development, and day-to-day operations. Decisions about funds allocation methodology, project budget development, and the Transformation Compact (see Program Management & Strategy Development below) are made by the **Waiver Finance Workgroup**, which is comprised of county commissioners, leaders from physical and behavioral health organizations, social determinant of health providers, Tribal health leaders, Rural Public Hospital Districts, MultiCare, Providence, and MCOs. (See Appendix 12 for the Waiver Finance Workgroup Charter). This group makes recommendations directly to the Board (not the Finance Committee) on MTD Project Funds, Community Resilience Funds, and Mid-Adopter Fully

Integrated Managed Care Incentive funding. The first set of funding allocation decisions were made at the November 2, 2017 Board meeting.

Clinical Oversight

The BHT ACH's clinical oversight strategy includes the **BHT Provider Champions Council** launched in November 2017. As described earlier in this section, the PCC provides clinical expertise and subject matter support in the development of the Transformation Compact (see Program Management & Strategy Development below) across the MTD Projects areas. The PCC will recommend key clinical elements and advise on clinical performance measures across projects to assess whether Collaboratives are on track to achieve expected outcomes. Additionally, the PCC will advise on proposed risk mitigation and continuous improvement strategies.

PCC members were recruited through outreach to our region's high Medicaid billers as well as nominations from Health Systems Inventories and Leadership Council Members. We specifically recruited for current practitioners who are embedded within the region's critical Medicaid provider settings with demonstrated trust and expertise in their field. Some key champions include:

- John McCarthy, MD, serves as Assistant Dean for Rural Programs at the University of Washington School of Medicine and is President of the Spokane County Medical Society. Dr. McCarthy is also the chief medical officer for The NATIVE Project and sees family medicine patients weekly.
- Brian Sandoval, PsyD, a clinical psychologist with 9 years of primary care experience in several capacities including clinical work, program development, policy, and research. He is the Director of the Primary Care Behavioral Health program at the Yakima Valley Farm Workers Clinic. Dr. Sandoval sees behavioral health patients weekly.
- Bob Lutz, MD, MPH joined Spokane Regional Health District as health officer in June 2017. Dr. Lutz served for eight years on the district's Board of Health and is a practicing urgent care physician for Multicare Rockwood Clinic.
- Jennifer Larmer, RN, serving as Chief Clinical Officer for Lincoln County Hospital District 3 with over 5 years' experience as a Registered Nurse in Odessa.

BHT will take steps to limit the risk of partnering providers ceasing to participate in the ACH by developing a process to ensure continuous quality improvement by monitoring outcomes and metrics that drive outcomes at provider and Collaborative levels. Partner engagement and fund distribution strategies will incentivize participation and achievement of milestones and goals. BHT will develop an early warning system to identify essential partners at risk for dropping out. In early 2018, BHT will execute contracts with partnering providers to be complete by June 30,

2018, which will serve as the contractual basis to sanction or remove underperforming providers from the BHT ACH work. The Provider Champions Council will recommend a framework for Board approval that will provide progressive sanctions prior to any action to remove the underperforming partnering provider from BHT Collaborative work.

For providers who cease to participate in the ACH, the BHT will take steps to re-engage and work with the partnering provider to assess performance barriers, the provider resource needs and ways BHT can provide assistance to support continued participation. It is anticipated these interventions will ensure buy-in and enhance the partners ability to achieve expectations over time. In the event the contract is terminated, there will be provisions for partnering providers to return any unused MTD funds to the Financial Executor in the event the participant fails to expend the funds in consideration of the services set forth in a Scope of Work.

Strategies for monitoring clinical outcomes and care delivery redesign

Our initial assessment of clinical capacity was conducted through self-reported information collected from 23 health systems via a Health Systems Inventory, which identified current and future capacity needs and plans. This scan informed project selection and findings will continue to be cross-referenced with other relevant data sources using analytic support from Providence CORE. BHT ACH is contracting with CORE to lead design and oversight of our monitoring system. CORE will serve as a shared resource across MTD projects and Collaboratives to provide timely information, data interpretation expertise, and both technical and strategic support for peer learning and continuous improvement.

Additionally, the Provider Champions Council will develop a framework to address provider needs and advocate for allocation of appropriate resources. The Waiver Finance Work group will align proposed financial incentives with clinical and project performance during the planning phase in 2018. The PCC will support shared problem-solving and learning, and provide support to providers who are struggling with implementation or having difficulty achieving metrics or reporting targets.

Strategies for incorporating clinical leadership

Clinical leadership is well-represented on the BHT Board, Leadership Council and Technical Councils, particularly the PCC and in the Regional Community Health Transformation Collaboratives. The Health Systems Inventories also served as an initial strategy for engaging clinical providers. As a measure of our success to date, inventories received covered all six of our BHT ACH counties and represented more than 80% of the high volume Medicaid billers in the region. Eight were from rural partners; three were from public hospital districts that include rural clinics; three from I/T/U partners, and four from FQHCs. We also received inventories from all high volume Medicaid behavioral health providers in the rural community and the largest provider in Spokane County, as well as both Providence and Rockwood/Multicare. The

BHT ACH will continue to engage with clinical providers to ensure participation in the Collaboratives and oversight of clinical outcomes and care delivery redesign.

We expect each Collaborative to engage with critical local partners needed to fulfill their project implementation objectives. Additionally, in its role as the Pathways Hub, the ACH will serve as a connector between Collaborative providers and additional social services and community partners who can support connections to social determinants of health.

Community Oversight

As BHT's ACH role expanded to include that of regional convener and backbone, we further developed our governance structure to include the Leadership Council. The combination of strategic alliances and engagement strategies ensures focus on the health status and priorities of the whole community so that no single entity, sector or person dominates the decision-making or activities of the ACH. Additionally, as described earlier, in December 2017 BHT will launch The Community Voices Council, comprised of at least 50% Medicaid beneficiaries, with the other half made up of community advocates with lived experience helping complex patients access and navigate community services.

Data Oversight

BHT is contracting with Providence CORE to lead the monitoring system design and oversight. CORE will serve as a shared resource across projects, coordinating with BHT staff and the entities above to provide timely information, data interpretation expertise, and both technical and strategic support for peer learning and continuous improvement.

CORE will support the ACH, Collaboratives, and ACH Technical Councils by supplying data and analytic support as requested and needed by ACH partners. The Collaboratives' role will extend to: advising on design of the self-monitoring system; regularly reviewing the data that the system provides; collaborating with the ACH to make course corrections as needed; and participating in shared learning opportunities within and across Collaboratives and ACH regions.

BHT has considered adding in a data workgroup, and potentially an HIE/HIT work group within our structure, however we do not intend to form additional workgroups at this time. Rather than separating this work out into its own group, our intent is to embed data-based decision making as a principle within the Collaborative, Technical Councils, and overall governance structure. Policy setting for HIE/HIT oversight will be driven by recommendations from the Provider Champions Council and Regional Integration Team. Bi-directional communication channels between the Councils, Board, and Collaboratives will ensure that information and recommendations are aligned between the different bodies.

BHT will support data-based decision making by:

- Inviting Collaborative/Council members to bring their staff with data expertise to meetings that will involve more technical material
- Providing each Collaborative with geographically-specific baseline / background data for their planning, and working with them to identify needs and gaps as they progress
- Identifying a data-analytic point person at BHT who can be on the ground to listen for data-related needs or opportunities in whatever venue they arise and can respond to simple data requests
- Continuing to engage data partners in our region ([e.g. SRHD, regional workforce development councils](#) for workforce data, etc.)

Data will also be reviewed regularly by our ACH Technical Councils, specific to the expertise of each Council. For example, our Provider Champions Council will recommend key clinical elements and performance measures across projects to assess whether Collaboratives are on track to achieve expected outcomes. The Community Voices Council will advise on metrics to evaluate how well project plans address health equity and will use these metrics to monitor and make recommendations for course correction as needed. CORE will support these Councils in providing data and analytic support, however Council members will drive decision making as to what metrics to monitor, and when it may be appropriate to modify measures.

Program management and strategy development

Projects will be developed and managed by the Rural and Spokane Health Transformation Collaboratives. The Collaboratives will be guided by a Transformation Compact developed in part by the Technical Advisory Councils that will include a strategic rubric of required elements, strategies and metrics, a funds flow framework, and assessment tools. The Collaboratives will be supported through regional infrastructure including consultants and BHT staff as well as support from the Technical Advisory Councils as needed. BHT will support regional coordination, cross sector/ cross region communication, and project management oversight.

BHT Positions include:

- BHT's **Executive Director** will provide leadership and strategy support across the region with a specific emphasis on ensuring regional policy alignment for FIMC, MTD, and ACO development. Additionally, the Executive Director will work to increase investment in Transformation efforts beyond MTD and increase funding for the Community Resiliency Fund. The Executive Director staffs the Waiver Finance Work Group, Regional Integration Team and BHT Board of Directors.
- BHT's **Director of Clinical Integration**, will provide Collaborative- and provider- level support on MTD clinical integration efforts. The Director staffs the Provider Champion

Council. Since submission of this original application, BHT has filled this position. We are excited to welcome Charisse Pope to our team, who joins us with a Master in Counseling Psychology and experience as a therapist. Charisse then moved into administration work supporting the Spokane County Regional Support Network, and served as Chief Business Officer for a youth behavioral health treatment center. We are confident Charisse's clinical and business experiences will add a wealth of content knowledge to our team, as well as the credibility and insider knowledge of working within health systems needed to build trust and support providers through systems change.

- BHT's Associate **Director of Health Transformation** will provide operational and strategy leadership on Community Care Coordination including directing the development of the Pathways Hub. The Director also provides leadership and strategy support to staffing the Tribal Partner Leadership Council.
- BHT's Associate **Director of Community Engagement** will provide operational strategy leadership on efforts to engage Medicaid Beneficiaries in MTD planning and implementation, as well as community engagement efforts, including staffing of the ACH Leadership Council and the Community Voices Council.

As noted in our bylaws, EHF is the sole member of BHT. It is important to note that this structure does not allow EHF to "control" the operations of BHT, rather it is designed to serve as an asset to propel and leverage work across the region to increase access to healthcare and transform the health system. BHT is governed, exclusively, by a community Board of Directors. EHF may appoint 1/3 of the board, but has not exercised this right since our inception.

Aside from the legal structure, BHT has benefitted from a contract with Empire Health Foundation to provide shared services related to Human Resources, Finance, and Communications. This has allowed BHT access to higher quality professional talent and support than what a start-up/small nonprofit would be able to afford. Additionally, we gain from the shared expertise and frequent investment by EHF to expand the reach of our work. For instance, EHF funded a federal grants consultant to ensure that our accounting practices would meet the highest standard for federal audits related to our MTD efforts. BHT has oversight and authority of our portion of the shared services staff, directing their work to meet the objectives of BHT. This includes the following staff:

- Jill Angelo, CFO for Shared Services
- Dani Doss, Accounting Manager for Shared Services
- Daphne Williams, Human Resources Director for Shared Services
- Kiana McKenna, Communications Coordinator for Shared Services

The Finance team is responsible for overall accounting, budgeting and reporting, including development and management of annual budget, processing of all expenses, disbursements, transactions, and journal entries recorded. The CFO is responsible for reviewing finances and reporting to the Executive Director on a regular basis. The Executive Director and CFO report to

the Board Finance Committee and the Board of Directors on financial results versus approved budget. The CFO is also responsible for the creation of annual financial statements for audit.

HR services provide support in recruitment, hiring, and onboarding of new staff as well as ongoing support and development of staff. This year, HR services revamped our out of date Employee Handbook to ensure compliance with all new federal, state and local requirements as well as aligning policies to ensure a healthy workplace.

Communications support include content generation and support for our weekly newsletter, website management, and content creation for meeting materials with the goal of maintaining timely and accessible flow of information out to our partners.

BHT will contract, as needed, with technical consultants and subject matter experts to support the development of assessment tools, funds flow arrangements, project plans, data and analytic strategy, and other specific technical assistance as needs of the Collaborative are surfaced.

Changes to Governance Structure since Phase 2 Certification

In addition to the new Technical Councils mentioned above and the Rural and Spokane County Health Transformation Collaboratives, BHT has added four new members to the Board of Directors: a county commissioner, a Spokane Tribe of Indians representative, the CEO of the largest regional FQHC, and the Chairman of the Board of the Spokane County Medical Society (who is also a practicing family physician). In order to include these important regional partners, BHT increased the size of the Board from 17 to 19 members in October 2017, when there were previously two Board seat vacancies. BHT also added 6 non-voting ex-officio County Commissioner positions.

Areas Identified as Needing Improvement in Phase 2 Certification

Comment: "Lack of clarity regarding how BHT will support board members in establishing regular communication tools to support ongoing feedback to their sector. The mechanisms are unclear."

To further support the expectation that Board members represent their sector and to improve sector communication, the BHT Director of Community Engagement drafts a summary after each Board meeting and presents it to Board members to be individually tailored to their particular sector and sent within a week of the meeting. (An example of this summary is provided in Appendix 13). This process ensures that, in addition to general BHT communication, the sectors that Board members represent have the most up-to-date information from a colleague in their sector. We have received positive feedback on this additional communication effort from several partners.

Comment: “Would appreciate additional discussion regarding the potential COI concerns that the policy is intended to address.”

A revised Conflict of Interest policy was adopted in July 2017 and is designed to guide Board Members in avoiding and being transparent about financial or other potential conflicts of interest. This policy is intended to address any circumstance under which a Board member may be influenced or may appear to be influenced by any purpose or motive other than the success, best interest, and well-being of Better Health Together. (See Appendix 14 for the updated Conflict of Interest policy). Our Conflict of Interest policy helps to assure transparency in Board discussions and decision-making, which is important for maintaining the trust of the community and partnering providers. The Board Chair opens each meeting by asking whether any member has a conflict. The Chair also has the right to determine whether another Board member has a conflict. Board meetings are open to the public.

Describe the process for ensuring oversight of partnering provider participation and performance, including how the ACH will address low-performing partnering providers or partnering providers who cease to participate with the ACH.

The Board has ultimate oversight of the implementation of MTD projects and outcomes. The Rural and Spokane County Collaborative structure will mobilize local efforts to transform the Medicaid delivery system. The Technical Councils set the requirements for success of the Collaboratives through the development of a framework and metrics of success and by identifying areas of improvement. The Provider Champions Council develops required clinical change elements, and provide oversight on clinical integration progress. The Waiver Finance Work group directs funds flow modelling and provides financial oversight. The Community Voices Council and Tribal Partners Leadership Council set goals for beneficiary and Native American health integration and health equity goals, and provide oversight on progress in those areas.

It is expected that our Funds Flow model will reward participation and achievement of metrics at a Provider and Collaborative level. This model allows for us to ensure broad Medicaid provider engagement throughout the region and reward performance.

BHT staff and Technical Advisory Councils will engage external subject matter experts as necessary in the development of necessary technical assistance and shared learning opportunities to support providers. BHT Staff will also facilitate shared learning across projects and partnering providers. Starting in Q1 of 2018, Collaboratives/Providers will be required to submit monthly progress reports to BHT ACH to trigger participation payments. This progress report will allow BHT staff to monitor progress and provide technical assistance where necessary. Additionally, via our Technical Councils, BHT intends to convene cohorts of partners to learn from successes and collectively problem solve challenges. In 2019, BHT will begin to utilize a community dashboard developed by CORE to monitor key metrics related to MTD and

community priorities. As we embark on the Collaborative planning process, BHT ACH is committed to work closely with partners to assess the best way to support both high performing and low-performing and to do so fairly and transparently.

Community and Stakeholder Engagement and Input

Community and Stakeholder Engagement and Input

The BHT *Meaningful Consumer Engagement and Meaningful Provider Engagement planning processes* involved several tiers of activity designed to secure input into the selection and planning of Medicaid Transformation Demonstration (MTD) and to yield a recommended policy and strategy for the BHT Board to consider adopting for ongoing meaningful engagement of consumers in future Accountable Community of Health (ACH) and MTD activities. The engagement processes were facilitated by Applied Insight. Two reports, 1) BHT Meaningful Consumer Engagement and 2) BHT Meaningful Provider Engagement, detail findings. (See Attachments 3 and 4.)

Meaningful Consumer Engagement

In total, 40 consumers participated in focus group discussions to inform the selection and planning of MTD projects for the BHT ACH region and to provide insight and ideas for establishing a long-term, meaningful consumer engagement strategy for ongoing ACH activities. The following groups were coordinated in partnership with a variety of community host organizations:

- Youth in Foster Care and/or Recently Aged Out of the Foster System (in partnership with Embrace Washington, Career Path Services, and Safety Net)
- Tribal Members and Urban Indian Community Center Visitors (in partnership with the American Indian Community Center and Empire Health Foundation)
- Rural Residents throughout Northeast Washington (in partnership with Rural Resources)
- Rural Residents throughout Lincoln County (in partnership with Lincoln County Health Department)
- Urban Residents throughout Spokane County (in partnership with Community Health Association of Spokane/CHAS)

Names of focus group participants are confidential, but host organizations verified attendance and group composition was validated for diversity to ensure the following characteristics were represented by the attendees:

- Geography (rural, urban, tribal)
- Race and ethnicity
- Gender

- Age
- Health conditions
- Social determinant needs

Meaningful Provider Engagement

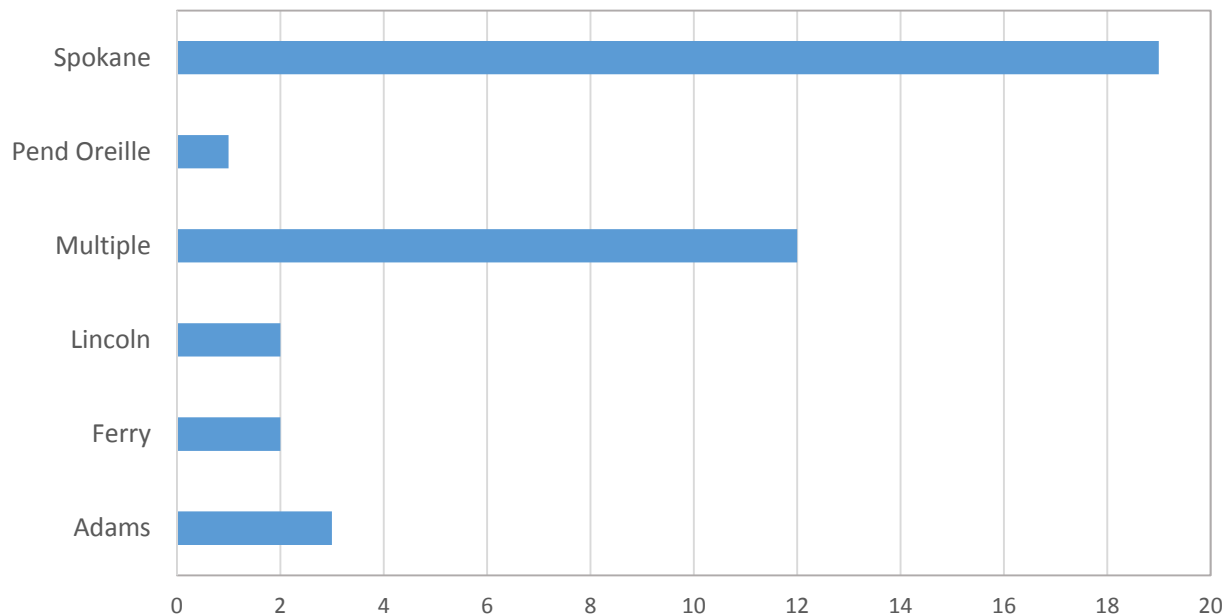
In total, 21 providers participated in key informant interviews and 24 providers participated in three separate focus groups to inform the selection and planning of MTD projects for the BHT region and to provide their insights and ideas for establishing a long-term meaningful provider engagement strategy for the activities of the ACH. Names of interviewees and host organizations for focus groups are included in the attached reports. Interviewees and focus group participants represented a diverse cross-section of providers according to the following criteria:

- Geography (rural, urban, Tribal)
- Race and ethnicity
- Health system/practice size and model (large, small, independent, university-affiliated, community non-profit, etc.)
- Sector representation (medical, behavioral, substance abuse, oral health, public health, MCO, etc.)
- Practice type/target population served (pediatric, geriatric, family medicine/primary care, internal medicine, tribal, homeless, psychiatric, etc.)
- Social determinants organizations (housing, food security, social services)

Health System and Care Coordination Inventories

In late August, BHT ACH conducted its Health System (HSI) and Care Coordination Inventories (CCI), seeking partnering provider perspectives on transformation (see Appendices 6 and 7). The comprehensive inventories have been utilized to inform decisions about how to structure our MTD planning efforts. BHT ACH offered a Pay for Reporting incentive to all partners who completed the inventories (excluding MCOs) of \$5000 for the HSI, and \$2000 for the CCI. The HSI was considerably longer, and asked for more patient level data, which accounted for the higher payout. In total 39 unique partners completed inventories, earning \$181,000 total. The number of inventory respondents (HSI or CCI) by county is shown in following chart; note that several participating organizations operate in more than one county and are listed under 'multiple.'

Figure 12: Health System and Care Coordination Inventory Respondents by County



Ensuring Transparency and Considering Public Input

The BHT ACH invests heavily in a robust website which includes the Leadership Council (LC) and Board meeting schedules for the whole year, as well as notes, documents and recordings from meetings. We regularly post synthesized content on our blog in an easy-to-digest format to support shared knowledge. We are especially proud of our Pathways videos, which were incredibly well received by partners. Additionally, all new information is shared in weekly ACH eNews update through MailChimp, which has increased from ~200 to ~300 subscribers since we submitted our Phase 1 certification. We are active Twitter users, and attempt to tweet about each meeting or discussions with partners to increase transparency.

The BHT Board hosts a public comment hour and open board meetings once a month, generally in Spokane at the Philanthropy Center; access is also available by webinar call-in. We also host a Board meeting annually in one of our rural counties. In May of 2017, we met at the Camas Path Center in Pend Oreille County on the Kalispel Reservation. The dates, location and agenda for upcoming Board meetings are posted in advance on our website. BHT staff provides a report of any public comment during the Board meeting and ensures public comments are reflected in the minutes. Once approved by the Board, the minutes from each meeting are posted on our website.

ACH Capacity Building

Since adding three more staff in May 2017, the BHT ACH has greatly increased its capacity to engage and seek feedback from community members. Central to our strategy is offering ACH staff time for local capacity building, such as staffing Rural County Health Coalitions or facilitating program design across partners. We've witnessed success in our engagement strategy through regular participation from a high number of diverse partners, who participate freely in conversation and contributing to the ACH's region-wide vision and strategy:

- Over 75 community members participated on a Community Strategy Action team.
- We received letters of interest (LOI) representing 90+ different project ideas from forty unique organizations
- 94 community members attended our Project Showcase in Spokane to provide feedback in project ideas, with representation from all six counties

This level of participation signals a significant level of commitment, especially when community members traveled to give feedback on project ideas. To support regional participation, BHT ACH offers to compensate mileage and lodging for rural partners. Our staff are quick to conduct outreach with any new organizations and community members who express interest or attend any of our meetings. Our Leadership Council now consists of 68 member organizations, with 10 new members added since September 2017.

Since Phase 2, the BHT ACH has launched a weekly Collaborative Learning Session webinar on Friday mornings, covering key strategies and activities of the MTD. These sessions are open to the public and all recorded and posted on our website.

Table 3: Collaborative Learning Session Webinars

Date (2017)	Learning Session Topic
October 6	RHNI Overview – how ACH uses data
October 13	Transformation Project Selection: 4 vs 6 vs 8
October 20	Behavioral Health Integration
October 27	Overview of Community Linkage Mapping
November 3	Regional Health Workforce Development

Provide examples of at

least three key elements of the Project Plan that were shaped by community input.

The BHT ACH has relied on community input to guide our process, with our regional priorities generated from community conversations across all counties and unanimously agreed to by our Leadership Council. We conducted over 40 meetings to build our **Community Action Strategy Maps**, which anchor the ACH efforts to members who participated in these work groups, including Medicaid beneficiaries who spoke to their experiences (see Appendix 1).

Key element 1: Participants in the community conversations described our region as having a wealth of passionate people and effective programs, but an inability to make large-scale population improvements due to a lack of high-level, outcomes-based coordination. Participants specifically noted the need to coordinate the coordinators. This feedback led us to explore the **Pathways HUB Model** for our SIM project, and the model now serves as a foundational strategy for the BHT ACH's MTD efforts.

Comments and themes gleaned from the provider engagement focus groups and key informant interviews described above led to the development of other key elements:

Key element 2: Providers identified: significant challenges in **care coordination and care transitions**; policy restrictions that impede the ability to coordinate care for complex patients; inadequate time with patients; and the need for training and **models that support the new integrated care team** and related systems changes both within clinical settings and between clinical and community providers. Additionally, most of the health care providers interviewed preferred a community-based approach to care coordination that seamlessly and effectively integrates into the clinical setting. One provider noted, "this should be housed outside of our, or anyone's, system and should follow/serve the needs of the client." This call out fits well with the Pathway HUB Model.

Key element 3: Through the project Letters of Interest and organizational Health Systems Inventories, providers reflected interest in all eight project areas, but also a concern about capacity to participate in eight projects. Additionally, many partners spoke to how interconnected each of the projects are. They warned against treating the MTD as separate projects and instead advised approaching it as one opportunity with multiple aligning strategies. This informed our decision to work with Collaboratives to build county based plans that address all four selected projects and desired elements of the other four projects collectively.

Describe the processes the ACH will use to continue engaging the public throughout the Demonstration period.

Feedback from our *Meaningful Consumer Engagement and Meaningful Provider Engagement planning processes* continues to validate and deepen the consumer and partner-driven priorities that were identified in our original strategy map sessions and community showcase. In our Board's public comment hour, key informant interviews and focus groups, and through Leadership Council feedback activities, we heard concerns from community members that

there was no clear mechanism for certain sectors to give input to project planning. While people see outreach happening, both providers and community members felt uncertain their input was being incorporated into regional plans. These concerns were also reflected in comments we received back from our Phase 2 certification.

In response, the BHT ACH has added two new Technical Councils to our governance structure since Phase 2 certification. These Councils were approved by the board on October 18th and were announced to the Leadership Council on October 25th. We distributed nomination forms for co-chairs and participants in these meetings, and also ran an online survey for nominations. Each Council will be co-chaired by a BHT Board member and Leadership Council member.

The Community Voices Council (CVC) will launch in December. Our intent is to recruit an initial group of representatives based on the first round of community nominations, and then task them with recruitment of additional members meeting our membership requirements. A draft charter for the CVC can be found in Appendix 15, to be finalized once the group is launched. Membership will be at least 50% Medicaid beneficiaries, with the other half of the group made up of community advocates with lived experience helping complex patients access and navigate community services. The CVC will help inform project planning by validating implementation plans against the needs and expectations of the beneficiary. The CVC will advise on metrics for evaluating how well project plans address health equity, and will use these metrics to monitor and make recommendations for course correction as needed. Members will receive a stipend from BHT for their participation, in recognition of the time commitment required. This group will also have evening and/or weekend meeting as the Council sees fit, and the BHT ACH will make arrangements to offer childcare support for meetings when needed.

The Provider Champions Council (PCC) hosted their first meeting on November 13th, meeting in the evening to accommodate the scheduling needs of providers who are generally with patients during the day. The PCC charter including membership can be found in Appendix 16. This Council provides clinical expertise and subject matter support in the development of the Collaborative Compact (an operational agreement for transformation in multiple settings of care) across the MTD Projects areas. The Council will recommend key clinical elements and advise on any needed clinical performance measures across projects to assess whether Collaboratives are on track to achieve expected outcomes. This group will meet monthly.

Describe the processes the ACH used, and will continue to use, to engage local county government(s) throughout the Demonstration period.

County commissioners have regularly participated in the Rural County Health Coalitions in Pend Oreille, Stevens, Ferry and Lincoln Counties. BHT staff have been actively engaging these county commissioners in this setting. The regional Behavioral Health Organization (BHO) Director served on BHT Board until her retirement on 10/31/17 (the BHO Director answers directly to county commissioners). And the BHT Executive Director has made several ACH presentations to county commissioners in various settings (see Appendix 17 for an example of a presentation).

BHT ACH engagement with county government regarding fully integrated management care (FIMC) has been proactive. When it became clear that the BHO was not actively hosting cross-sector conversations regarding the impending decision to become a mid-adopter of FIMC, the BHT ACH convened the Regional Integration Team (RIT) to develop a regional approach to address the state mandate for Fully Integrated Managed Care and ensure alignment with MTD integrations efforts. Membership for the RIT includes county commissioners from each county, the BHO director, behavioral health and physical providers, and MCOs. This group accelerated the FIMC discussion, ultimately leading to all six counties agreeing to be a mid-adopter for Fully Integrated Managed Care on January 1, 2019. The ACH played an important role in getting unanimous commitment for FIMC mid-adoption. As late as June 2016, there was little commissioner interest in moving to FIMC. BHT staff worked tirelessly to understand concerns, develop strategies to alleviate risk, and demonstrate a shared role for the ACH and counties. For example, county commissioners expressed concern about the ACH being another level of bureaucracy. To alleviate concerns that the BHT ACH would take valuable service dollars, the BHT Board passed a policy to waive the administrative fee to administer the FIMC incentives so that all funds would go towards integration efforts.

Going forward, each Board of County Commissioners in the BHT region has been invited to join the Waiver Finance Work Group. The BHT Board has also added an ex officio member policy, allowing each county to send a Commissioner Representative. There has been regular, in-person participation from all counties. In October 2017, Commissioner Mike Manus of Pend Oreille County was appointed to the BHT Board.

County Commissioners will also be invited to actively participate in implementation planning with the Collaboratives. Commissioners will be key leaders in integrating jail diversion and transition strategies as well as aligning prevention-related strategies through their membership in their local county Board of Health. The Regional Integration Team will meet in early December 2017 to resume the work of aligning FIMC and MTD efforts, and BHT expects to have continued active engagement of county commissioners in these efforts.

Discuss how the ACH addressed areas of improvement, as identified in its Phase II Certification, related to meaningful community engagement, partnering provider engagement, or transparency and communications.

As noted above, the BHT ACH has added two additional Technical Councils to the governance structure since Phase II Certification to elevate the voices of consumers and providers: the Consumer Voices Council and the Provider Champions Council. Since Phase 2, BHT has also launched a weekly Collaborative Learning Session webinar on Friday mornings, covering key strategies and activities of MTD. These sessions are open to the public and all recorded and posted on our website. We completed collection of our Health Systems and Care Coordination Inventories to gather feedback and information from clinical and community-based providers. We have also made our Board of Directors meetings open to the public. Lastly, the BHT ACH has

made improvements in communications tools for Board members who are sector representatives.

Tribal Engagement and Collaboration

Tribal Engagement and Collaboration

Communication and meeting with tribes

In August 2016, Better Health Together (BHT) Staff and Board members participated in a Native Health Systems learning session sponsored by the American Indian Health Commission at The NATIVE Project, including a facilitated conversation about how to increase and support collaboration between IHS/Tribal/Urban health facilities and the ACH.

Tribal representation on ACH Board

The BHT Governance Committee, with support from the BHT Board, prioritized Tribal representation by appointing two of four open seats to Tribal representatives. BHT ACH accepted open applications and used a community-driven process for nominations. We also sent announcements of the nomination and application process directly to representatives of each of the Tribes in our region and The NATIVE Project. Two members, representing the Kalispel Tribe of Indians and the Confederated Tribes of the Colville Reservation, were elected through this process. The Board unanimously approved the slate of new officers, and their terms began January 2017. A third Tribal partner was added in October 2017, representing the Spokane Tribe of Indians. With this final addition, the BHT Board has representation from all three tribes in the region.

Tribal Leaders Partner Council

At the request of Tribal members on the BHT Board and to support further active engagement, the BHT Board created the Tribal Partners Leadership Council (TPLC) and appointed the two Tribal Board members as the co-chairs in March 2017. The BHT ACH TPLC serves as a forum for continued partnership, education, and shared learnings with IHS/Tribal/Urban health facilities and Tribal Organizations as ACH work develops with a specific focus on providing impact analysis on projects and Board policy decisions.

BHT ACH is continuing specific efforts focused on relationship-building and collaboration with Indian Health Service providers, Tribal Organizations, and Urban Indian Health Centers (I/T/U) in our region. Identified regional Tribal partners include The Confederated Tribes of the Colville Reservation, Spokane Tribe of Indians, Kalispel Tribe of Indians, The Healing Lodge of the Seven Nations, The NATIVE Project, The American Indian Community Center, and Lake Roosevelt Community Health Centers. Leaders from these health systems are invited designees for the TPLC.

ACH Staffing

Better Health Together ACH hired an ACH Tribal Senior Project Manager to work collectively and individually with each of our Tribal partners. This staff member is an enrolled member of the Yakama Nation and has worked for the Kalispel and Yakama Tribal governments. Most recently she served as the Communications Manager for The NATIVE Project, and in recent months, was promoted to Associate Director of Health System Transformation. In this role, she continues to travel frequently between Native health leaders to support engagement, open communication, trust, and opportunities for collaboration alongside Tribal communities as we develop our Community Health Transformation Collaboratives and look for alignment and leverage with the statewide ACH Tribal efforts.

Identification of Tribal priorities

Addressing health disparities of American Indian and Alaska Native (AI/AN) people in our region has been identified as a priority issue for Tribal representatives. Attendees at TPLC meetings have identified mental health and substance use issues, including lack of access to treatment and providers, as key areas of need. The Community-Based Care Coordination and Opioids Projects were identified as the two project areas that should be prioritized for collaboration. This feedback was included in all of our Board deliberations about project selection and collaborative development.

How Tribal priorities have informed project selection and planning

Better Health Together ACH conducted region-wide Health Systems and Care Coordination Inventories, which are being used to further refine regional priorities and assist in project development and planning. Recognizing the need to include culturally competent evidence based care models, we asked about current use of specific models that the I/T/U partners may reference in their health system transformation efforts (e.g. the Indian Health Service's Improving Patient Care program, which supports outpatient teams to achieve patient-centered medical home recognition). BHT ACH is closely following the Tribal statewide efforts of the Indian Health Care Protocol (IHCP) and would like to assist our Tribal Partners where possible. One component of the IHCP is improvement of behavioral health for AI/AN Medicaid clients, adopting a trauma informed approach. This is in line with BHT ACH's Bi-Directional Integration Project Plan. IHCP initiatives also include workforce capacity and HIE/HIT, and BHT ACH is committed to providing technical and project support to I/T/U partners as planning and project implementation continue.

Examples of elements of the Project Plan that were informed by Tribal input

On June 19, BHT ACH hosted a six-hour work session for the TPLC. Tribal partners shared health systems updates and challenges. One common theme identified between the health systems is of lack of workforce available in their rural areas, along with retention and ongoing provider development opportunities. BHT ACH gave a Medicaid Transformation Demonstration (MTD) funding overview and provided an update on health system transformation planning activities,

all of which work to address the issues identified by our Tribal partners. Attendees identified a need to work together to address mental health and substance use issues. This informed our population focus for our MTD-required Bi-Directional Integration Project.

The July 25 BHT ACH TPLC meeting was held at the Camas Community Center for Wellness in Usk, WA. The group discussed the MTD Tribal Protocol for the DSRIP Program, and Phase I and II Certification processes. This included briefings and a feedback session on all BHT Board policies to be adopted at the July Board meeting. Attendees concluded that they would like to focus on collaboration for shared resources on Community-Based Care Coordination and the Opioid Projects. This feedback was included in our decision-making process to select the Community-Based Care Coordination project.

At the request of the TPLC, the BHT ACH Associate Director of Health System Transformation is part of a statewide weekly call with Tribal health providers and other ACH Tribal engagement staff to discuss a coordinated strategy to address opioids. This discussion led to a recommendation to include The Six Building Blocks for Safer Opioid Prescribing as a desired element of the clinical strategies for Opioids in the Collaborative implementation plans.

Throughout our TPLC discussions, we have identified a need to invest in improving health inequities. These discussions spurred the conversation with the Medicaid Waiver Finance Team to include a funds use category referred to as the Equity Accelerator Payment, acknowledging the likelihood that more costs are incurred to serve populations with historical trauma.

If Tribes/ IHCPs are not involved in ACH project selection and design, describe how the ACH is considering the needs of American Indians/Alaska Natives in the ACH region

N/A

Discuss how the ACH addressed areas of improvement identified in it Phase II Certification related to Tribal engagement and collaboration.

Each of the BHT ACH Technical Councils have appointees from the TPLC to ensure appropriate levels of feedback and engagement. We currently have active participation from Tribal Partners in the Waiver Finance Work Group, Regional Integration Team and Provider Champions Council. (See Governance section for Council roles.) We are actively recruiting for Tribal representation on the soon-to-be launched Community Voices Council, our mechanism for direct community and consumer input. Additionally, both The NATIVE Project and Lake Roosevelt Community Health Centers completed BHT ACH's Health Systems Inventory (HSI). We are working with the other Tribal partners to complete the HSI in preparation for the launch of our Rural and Spokane County Collaboratives. We have received letters of support from the Kalispel Tribe of Indians, The Confederated Tribes of the Colville Reservation, Lake Roosevelt Community Health Centers, and the American Indian Community Center; these can be viewed in Attachment 5. We continue to actively communicate and collaborate with our Tribal Partners and are excited about the addition of a representative from the Spokane Tribe of Indians to the BHT Board.

Funds Allocation

Funds Flow Oversight

Over the course of the Medicaid Transformation Demonstration (MTD) period, the Better Health Together Accountable Community of Health (BHT ACH) will build region-wide capacity for improving community health and preparing the region for value-based care. The BHT ACH will leverage MTD investment with other funding initiatives to drive strategy, partnerships and capacity necessary to stand up a critical, innovative and sustainable system for long term improvements to community health.

The BHT ACH is purposefully constructed to ensure broad multi-sector, geographical, and cross-organization collaboration. To this end, the BHT ACH has developed a tiered governance and engagement structure with distributed decision-making, joint ownership, and mutual accountability that drives innovation and fosters co-investment. While the BHT Board of Directors retains its authority as the final decision-making body for MTD efforts related to project selection and funds flow management, it is the intent to utilize many mechanisms for partners, providers, community, and stakeholders to provide feedback and influence final decisions. Board and technical members are expected to disclose any actual or perceived conflicts of interest as they relate to sector-affecting decisions and/or the BHT ACH. In July 2017, the BHT Board approved a comprehensive personal and organizational Conflict of Interest policy (see Appendix 14).

The BHT ACH Leadership Council, whose broad participation helps us synthesize local priorities into regional strategies; and representatives of our local health networks have informed our regional health priorities and inspired the creation of the Rural and Spokane County Collaboratives to develop and implement the MTD projects.

Additionally, the Board has appointed Technical Councils to provide deeper feedback on the complex elements required to successfully implement the MTD efforts, such as:

- Tribal Partners Leadership Council (TPLC)
- Provider Champions Council
- Community Voices Council
- Medicaid Waiver Finance Workgroup
- Regional Integration Team

To align with ACH values for local control and to build on the strength of geographic based health coalitions, the BHT ACH will utilize a Community Health Transformation Collaborative (Collaborative) model to develop and implement geographic based systems of care plans in the four project areas BHT ACH selected. The Collaboratives will be guided by a Collaborative Compact, which includes activities and strategies needed to implement the required MTD projects, meet local community priorities, drive achievement of metrics, and serve as the mechanism for providers to earn MTD dollars.

The Better Health Together ACH uses a two-pronged approach for financial oversight. Procedures are in place for decision-making by the Waiver Finance Work Group and BHT Board Finance Committee to ensure stewardship of MTD projects.

The Board of Directors serves as the primary decision-making body for the oversight of BHT activities. The Board provides strategic direction and establishes policies to provide oversight of MTD funds throughout project implementation, including payment distribution direction to the financial executor. The BHT Board Finance Committee is charged with reviewing detailed financial performance, recommending annual budget and ensuring that there are sufficient resources to carry out the work of BHT. The BHT Board Finance Committee will oversee appropriate use of MTD funds directed to BHT by the policy recommended by the Waiver Finance Work Group and approved by the Board of Directors. For instance, we envision investment of Year 1 funds in the Pathways Hub development. These funds would be allocated via the Waiver Finance Work Group policy for Regional Infrastructure. Once these funds were approved by the BHT Board, the BHT Board Finance Committee would ensure appropriate expenditures to meet the programmatic objectives.

The Waiver Finance Work Group develops policy for board approval for the MTD Funds and provides oversight of the MTD funds flow methodology and distribution plan to ensure joint ownership and mutual accountability. The work group gives recommendations to the BHT Board for approval of all MTD funds budgets, allocations and distribution plans, including distribution to the ACH for Project Management and Administration. Additionally, the BHT Board has adopted conflict of interest policies for Board and Technical Council members, which defines conflicts of interests and outlines expectations to take appropriate action on matters of which there are conflicts of interest.

The Waiver Finance Workgroup is charged with recommending to the BHT Board a methodology for the MTD funds including:

- Develop and recommend to the BHT Board for approval, a set of policies to govern the Project and Integrated Managed Care Incentive funds including a detailed approach for Collaboratives and partnering providers to earn pay for reporting and pay for performance achievements.

- Review and recommend to the BHT Board for approval each Collaborative Demonstration financial plan;
- Provide oversight of Demonstration activities to ensure compliance with waiver requirements.

The Waiver Finance Work Group is comprised of a TPLC appointee, an FQHC appointee, County Commissioners, physical and behavioral health providers, Providence Health System, MultiCare Health System, public hospital leadership, community based organizations, philanthropy, aging and long-term care, and BHOs/MCOs. (See Appendix 12 for the charter and membership list).

The Waiver Finance Workgroup recommended, and the board approved, the following principles as a foundation for the funds flow development:

- **Values:** rewards innovation, supports collaboration, recognizes at-risk and vulnerable populations, supports diversity of partners and approach in the market, drives maximum impact to number of lives served, maximizes financial resources for the region.
- **Equity:** Ensures investment addresses disparities and health inequities for the Medicaid beneficiary; ensures a focus on increased access to culturally appropriate care.
- **Flexible:** Able to change models and approaches over time (i.e. does not lock in funding only on certain approaches), meets the needs of the individual collaborative hub, mitigates appropriate provider risks, and recognizes the value and cost of “sweat equity.”
- **Fairness:** Balances 1) equity to all partners with intended impact, 2) seed money with sustainability and longer-term impact, and 3) smaller, less efficient providers’ needs with those of the larger providers.
- **Alignment:** Ensures alignment between funds flow and intended goals (appropriate care in the appropriate environment); healthcare as an economic development tool. Encourages and promotes alignment between partners, supports integration among the providers (both rural and urban) to prepare the region for value based payments, aligns efforts with other Medicaid, Medicare and local initiatives, complies with HCA criteria, aligns continuum of care between rural and urban regions

It is expected that in early 2018, the BHT ACH will execute memoranda of understanding (MOU) with its partnering organizations that will stipulate the specific roles and responsibilities of each party. This MOU will serve as the foundation for contracts with each provider to detail requirements for earning dollars including (likely) monthly reporting of pay-for-reporting and quarterly pay-for-performance achievement. In consideration of the execution of the MOU, the

Waiver Finance Workgroup will recommend to the BHT Board for approval, a methodology for distribution of Year 1 Incentive funds in the first quarter of 2018.

Prior to submitting distribution direction to the Financial Executor, it is expected that BHT leadership will present, for board approval, payments to be made based on achievement of agreed upon contractual terms.

Additionally, please note that the BHT Board of Directors has a Board Finance Committee charged with oversight of BHT finances. Responsibilities include, but are not limited to, overseeing the ACH's financial structure and monitoring the budget, including MTD dollars approved and distributed to BHT by the financial executor. The BHT Finance Committee also oversees other BHT funds including investments by local philanthropy and the Navigator contract with the Health Benefit Exchange. This subcommittee reports monthly to the Board on current status of BHT's finances and performance to annually adopted budget. This subcommittee provides financial oversight of MTD dollars distributed to the ACH for the administration of the DSRIP program, including Phase I and Phase II Certification dollars, and regional investment allocated via the Waiver Finance Workgroup for activities such as the establishment of the Pathways Hub. One BHT Board Finance Committee member serves on the Waiver Finance Workgroup. The Executive Director will submit to the BHT Board Finance Committee for approval the monthly financial statements and performance to the annually adopted budget. These reports are reviewed by the BHT Board Finance Committee and then approved by the Board of Directors.

Finally, BHT contracts with the Empire Health Foundation for back office services including accounting and finance support services. This contract includes CFO and finance staff capacity. In 2018, the BHT Board will adopt a formalized set of policies and procedures to ensure federal and state compliance with all current contracts. Additionally, BHT ACH will implement a new accounting platform, NetSuite, that will easily allow for tracking of time and expense to federal grants. NetSuite provides accurate, real-time financial reporting of grant costs across the organizations for grants required tracking. NetSuite will allow tracking of expenses against specific revenue sources down to the transactional level. This ensures a deeper level of financial accountability for MTD funds.

Describe the ACH process for ensuring stewardship and transparency of DSRIP funds over the course of the Demonstration.

The Waiver Finance Workgroup Charter stipulates expectation of members to:

- Provide stewardship and management of BHT ACH Waiver Financial resources;
- Keep the best interest of the BHT ACH and the community at the forefront of discussion and decision-making.

BHT ACH is committed to transparency and accountability for how MTD funds are spent and the impact on meeting MTD and regional goals. Using the board-approved funds flow guiding principles and use categories, contracts will be developed with providers to ensure accountability between funds distributed and achievement of pay for reporting and pay for performance goals. To mitigate performance risks, BHT will develop a review process to ensure that providers meet reporting and performance metrics. This regular reporting process will allow for course correction via technical assistance and a dependable manner of funding for partners. The BHT staff will ensure all payments are aligned with governance, contract requirements prior to seeking approval from the BHT Board, whose approval will direct the financial executor to release payments.

It is the expectation that funds flow methodology and ability to earn dollars will be clearly communicated through several channels including weekly BHT ACH communication, Open Board meeting, Leadership Council meetings, minutes from Waiver Finance Work group, BHT website and community presentations. It is expected that feedback will be provided by the other technical advisory groups to ensure programmatic alignment with suggested funds flow methodology. Additionally, at a Collaborative level, all partners will understand how funds will flow across partners and via the Rural and Spokane County Collaboratives.

If applicable, provide a summary of any significant changes since Phase II Certification in state or federal funding or in-kind support provided to the ACH and how the funding aligns with the Demonstration activities.

There are no other significant changes to in-kind support or additional state or federal funds since Phase II Certification. However, the BHT ACH has launched conversations with local funders to develop a match investment to our Community Resiliency Fund. Additional exploration of other philanthropic efforts to support clinical transformation efforts for maternal and child health and oral health is building momentum.

The BHT ACH will continue to leverage investments from SIM and the Empire Health Foundation to support our region's health transformation and community efforts. We are under contract with the Washington Health Benefit Exchange to administer our region's Navigator Network, to ensure that people in our region have access to health insurance.

As part of the Collaborative reporting process, the BHT ACH will require partners to track in-kind services and leveraged local, state and federal investments. We expect to demonstrate partner's investment for data sharing, clinical provider champions, community benefit, meeting spaces, recruitment, and donated staff time to support governance, strategic development, training and program management.

If applicable, provide a summary of any significant changes to the ACH's tracking mechanism to account for various funding streams since Phase II Certification.

There have been no significant changes to the BHT ACH's tracking mechanism to account for various funding streams since Phase II Certification. In 2018 BHT ACH will launch a new accounting system that will allow for more in-depth reporting and federal grant compliance.

Project Design Funds

Describe, in narrative form, how Project Design funds have been used thus far and the projected use for remaining funds through the rest of the Demonstration.

Phase 1 and 2 project design dollars are allocated by BHT Board policy and managed by the BHT Executive Director and BHT Board Finance Committee. In July, the Board earmarked funds for distribution in 2017. In December 2017, the Board will approve the 2018 budget with additional allocations from Phase 1 and 2 project design dollars. The BHT Board Finance Committee meets monthly to review financials including a projected year-end spending plan. In December, unspent and allocated reserve funds will be apportioned in the 2018 Budget.

The BHT ACH will continue to utilize project design funds to build the capacity of our internal and community teams to prepare for project planning and implementation. Year-to-date, we have expended approximately \$391,000 of the \$6 million received since June. Notably, \$106,000 has been distributed to partners for successful completion of Health System and Care Coordination Inventories.

Additional funds have been expended for:

- Central service administration, including BHT leadership and staff, shared service agreements for finance, HR, and communications support and operations;
- Contracted services with KPMG, Providence CORE, and Uncommon Solutions to support financial, facilitation, data, and collaborative project development;
- Project development activities, including travel;
- Community member stipends for participation in focus groups; and
- Website design

\$870,000 of project design funds are reserved for:

- BHT ACH administration / project management during the remainder of 2017 and 2018 (balance of \$270,000)
- Investment in the Community Resiliency Fund aimed at strengthening services that support social determinants of health (\$600,000)

Subject to Board approval, it is anticipated remaining funds will be used for continued support of:

- **BHT ACH Project Plan:** Contracted services to support financial, data and collaborative project development.
- **Engagement:** Activities with both consumers and clinicians, including funding to support partners for time and space provided, and to community member stipends for participation in the focus groups.
- **ACH Administration Project Management:** Central service administration, including leadership and staff, shared service agreements for finance, HR, and communications support and operations.
- **Health Systems & Community Capacity Building:** As needed to support regional infrastructure investments such as the development of the Pathways Hub.
- **Collaborative Development:** As need to support investment in Collaboratives.
- **Other:** Reserves per Board policy to be spent by the end of the demonstration period.

Beginning in early CY 2018, Design Funds will be supplemented by an allocation of 5% for administrative dollars from project funds, per the BHT Board approved funds flow.

Funds Flow Distribution

Describe the ACH's anticipated funds flow distribution. Describe how Project Incentive funds are anticipated to be used throughout the Demonstration. Provide a narrative description of how funds are anticipated to be distributed across use categories and by organization type.

In November 2017, the BHT Board approved 4 projects to maximize earning potential for the region and provide maximum local control over transformation efforts customized to the region. The BHT ACH will align data, funds flow and model development to maximize the opportunity to integrate selected projects into a value based model and weave together local resources and investments to reach this goal. Our funds flow plan includes directed investments for startup costs, infrastructure and technical assistance emphasizing DSRIP funding for transition, not an ongoing service payment stream.

The Waiver Finance Workgroup recommended, and the BHT Board approved, the following principles focused on meeting the funds flow needs of our partners:

- **Values:** BHT ACH needs to know that the organization and work will make a difference if funds are accepted. Money from the DSRIP efforts should be available across the current silos, support latitude to try different things, incentivize collaboration, better

flow of information, and communication with new and expanded partners, support innovations that stimulate cost curve bending approaches.

- **Business Practices:** Projects need to not lose money (revenue and profit) in the transformation. The BHT ACH helps mitigate financial risk for partners, but funds should NOT be restrictive and complicated to track, and should support reorganization of services in a geographically widespread area with siloed service. Funds are used to develop a region-wide shared savings model with appropriate investment in regional-level infrastructure, alignment to HCA targets (MCO goal) and BHT ACH region goals, and garner the broad support from the provider community.
- **Operational:** Funding should provide the ability to integrate medical and behavioral health records, and support infrastructure needs, e.g., Behavioral health locating to the campus where primary care physicians and hospitals are located. Effective patient flow between the various services that are provided is a priority as is timely payment methodology for healthy cash flow. Clarity is needed in the method to request and qualify for funds, and what deliverables/commitments are required in return. Funds are expected to support sustainable efforts that span beyond the five-year demonstration period. Funds flow incentives align with the VBP efforts and associated incentives (e.g. using the same metrics).

The BHT Board adopted a high-level funds flow framework that consists of the following elements:

- Funds used by the BHT ACH for DSRIP project management and ACH-wide investments and support for the benefit of all Collaboratives, subdivided into projects such as HIT/HIE, workforce and community engagement.
- Fixed funds to support Collaboratives with DSRIP project management and project costs.
- Performance-based funds to help align Collaborative incentives with those to which the ACH is held accountable during the demonstration, such as engagement criteria, outcomes, and reporting requirements.

The Waiver Finance Workgroup recommended, and the BHT Board approved, four investment areas for funding: ACH DSRIP Management (5%), Regional Partner Investments (30%), Collaboratives (55%), and Community Resiliency (10%) The funds flow plan applies five use categories for distribution: Administration and Project Management; Project Engagement, Participation and Implementation; Provider Performance and Quality Incentive Payments; Health Systems and Community Capacity Building. The BHT Board approved, a Community Resiliency Fund.

The use category distribution plan provides for:

- Administrative operating expenses of the ACH, including: financial, legal, administrative salaries, facilities and equipment, B&O taxes.
- Fixed payment for engagement and participation (signed partner agreements, and meaningful leadership and participation on workgroups and operational committees); implementation costs for early infrastructure and process changes that actively move the partner and partner group toward integration and community-based care;
- Earned payments for reporting on project milestones; performance-based, metric-driven payments; transitioning to new payment models. Additionally, the Waiver Finance Workgroup is exploring the ability to fund an equity accelerator payment to reduce health disparities
- Regional investments in: population health management systems (EHRs, HIE/HIT, data); strategic improvement/quality improvement activities; workforce development; value-based payment technical assistance; revenue cycle management and supply chain management support; Pathways HUB operations; training and education on preventing provider fatigue, and community and provider engagement;
- Regional investments that promote long-term transformation and impact issues affecting population health, with a focus on primary prevention and social determinants of health.

Using the board-approved funds flow guiding principles, allocations by use category and distribution by organization types were established. BHT ACH approached the funds flow distribution methodology for four projects with consideration toward the recent HCA reduction to Year 1 waiver revenue, and the uncertainty about funds availability in subsequent years. Understanding our Collaboratives will customize local solutions, we considered an Average Pay-for-Reporting Achievement Value of 100% across all four years and Average Pay-for-Performance Achievement Value of 75% vs 90% across all three years.

Table 4: ALLOCATION OF PROJECT FUNDS BY USE CATEGORY

Use Category	5-Year Total
Project Management and Administration	5%
Provider Engagement, Participation and Implementation	32%
Provider Performance and Quality Incentive Payments	23%
Health Systems and Community Capacity	30%
Community Resiliency Fund	10%

The Waiver Finance Workgroup recognizes the importance of distribution to community-partners and providers to spearhead regional community-led initiatives aimed at strengthening social determinants investments. Provisions will be made to distribute the Community Resiliency Fund to partnering organizations to support linking health care system to social determinants of health. The BHT ACH will seek to match MTD funds in the Community Resiliency Fund with other community benefit dollars from funders like Empire Health Foundation, community benefit investments from Providence, MultiCare, Inland NW Community Foundation, United Way, and others. By aligning partners and investors around these indicators, using MTD funds as an incubator, we can create an investment fund of flexible dollars for the region to continue to use for strategic investment in overcoming health disparities and social determinants of health. We see this fund as a mechanism to negotiate cross sector shared savings model to provide a longer term funding strategy. Please note it is the intent of the BHT ACH to expend all MTD Community Resiliency Fund dollars during the MTD period.

A Collaborative structure will be used to incentivize shared accountability tied to outcomes for population health. The Collaboratives will be comprised of Medicaid, Non-Medicaid Providers and Tribal Health Systems designed to build on the rural County Coalitions structure and leverage the natural partnerships needed to support a geographically based system of care so the region can succeed in a value based system. Partnerships will sustain themselves as business models adapt to value based contracts and it is expected the opportunity to invest in a shared savings will provide additional capital to continue MTD efforts. The support from the BHT ACH, MTD funds, and the Collaborative partners will foster an environment of innovation and transformation.

Table 5: ALLOCATION OF PROJECT FUNDS BY ORGANIZATION TYPE

	DY1 – 2017
ACH	10%
Medicaid Providers	70%
Non-Medicaid Providers	10%
I/T/U	10%
Other *	0%
	100.0%

Going forward, guided by the principles of collaboration and accountability, the allocation of MTD funds to partnering organizations will contemplate the value of the project, target population, level of resource and commitment by partner, readiness and expertise, financial resources and success in achieving milestones and outcome goals.

Attestations

- Attest to whether all counties in the corresponding Regional Service Areas (RSAs) have submitted a binding letter of intent (LOI) to integrate physical and behavioral health managed care

YES	NO
X	

- Attest to whether the ACH region has implemented fully integrated managed care.

YES	NO
	X

- If the ACH attests to having implemented fully integrated managed care, provide date of implementation.

DATE (month, year)	
--------------------	--

- If the ACH attests to not having implemented fully integrated managed care, provide date of projected implementation.

DATE (month, year)	January 2019
--------------------	--------------

How Integrated Managed Care Incentive funds will be used or invested

BHT ACH views the transition to Fully Integrated Managed Care (FIMC) as a requirement to successfully transform the health and social determinants of health systems and successfully shifting to a value based payment and care model.

To support regional decision making on FIMC and alignment on clinical integration for physical and behavioral health, the BHT ACH formed a Regional Integration Planning Team. The team is comprised of key stakeholders in the region including County Commissioners from Adams, Lincoln, Stevens, Pend Oreille, Ferry and Spokane County, MCO representatives, rural health leadership, Providence, MultiCare, Physical Health and Behavioral health providers, Tribal Partners Leadership Council appointee, and the Spokane County BHO Director. As noted at a meeting in late July, “this is the first convening of key partners in physical and behavioral health, as well as county officials discussing the needs of our region’s health system.” The initial

goal of this to team was to identify an approach to meet the state mandated 2020 deadline for Fully Integrated Managed Care.

To demonstrate good intent and reinforce the ACH belief that FIMC is critical to transforming the health system, the Board passed a policy in August 2017 noting that if the region was a Mid-Adopter, the BHT ACH would not take any administrative expense of FIMC incentive dollars and would direct all FIMC Incentives to support the integration of physical and behavioral health providers.

On October 16, 2017, County Commissioners submitted a binding letter of intent to move to Mid-Adopter on January 1, 2019. The BHO and HCA are still finalizing details, but it is the expectation of the region we will implement FIMC on January 1, 2019. The Commissioners from around the region continue to discuss the role of the Spokane County BHO transitioning into serving as the region's Behavioral Health Administrative Services Organization. This decision is due to HCA by early January 2018.

The Waiver Finance Workgroup will develop a methodology for distribution of funds in two categories: regional infrastructure and Collaborative investment, in early 2018. This methodology will align with our bi-directional integration efforts and will seek to maximize the spend down of the BHO reserves Spokane County current holds.

Required Domain 1 Focus Areas

The BHT ACH Rural and Spokane Collaboratives will serve as the local experts to identify needs and develop a plan for all selected projects and activities. BHT will act as the aggregator across the Collaborative to ensure standardization, coordination, collaboration and regional accountability. Each Collaborative will create an interconnected plan across all project areas for each Domain 1 element using a systems approach, with assistance from the BHT ACH as the aggregator and system funder. BHT ACH earnings will be used to encourage adoption of standard practices and to incentivize the completion of the Collaborative assessments.

Concrete next steps for each Collaborative are as follows:

- Q1 2018: Each Collaborative will conduct a standardized needs/gap assessment for each project area based on the Collaborative Compact.
- Q1 2018: Based on findings, BHT ACH will develop a collective approach for collaborative and system-wide capacity development related to workforce, VBP and population health management.
- Q1 2018: Implementation planning and development (using baseline targets from HCA and BHT ACH regional priority goals).
- Q3 2018: Implementation Plans due.
- Q4 2018: Incorporation of collective approaches to develop and reinforce statewide strategies and capacity through a BHT ACH All-Collaborative convening.

Four BHT ACH investment categories have been identified:

- **ACH DSRIP Management,**
- **Regional Partner Investments** (including HIE/HIT; Population Health Management; Training; Workforce Development; Project Management; and Pathways Hub),
- **Collaborative** (fixed and earned payments to members of the Collaborative), and
- **Community Resiliency Fund.**

The BHT ACH will serve as a convener across the region, with the Rural and Spokane Collaboratives serving as the activation network for achieving ACH and Medicaid Transformation Demonstration (MTD) goals and outcomes. The BHT ACH will facilitate and drive alignment across the region to leverage additional resources and strategies among partners, providers, and funders. For example, the Community Resiliency Fund may serve as a

mechanism to align needed social determinant investment across philanthropic partners, allowing MTD resources to have a greater impact. As another example, we are in discussions with the Empire Health Foundation and Upstream USA to support increased regional efforts to reduce unintended pregnancies through the utilization of the One Key Question model, and increasing access to Long Acting Reversible Contraception. This partnership will allow the BHT ACH to leverage MTD funds to add additional elements to the clinical delivery system. This also meets our region's desire to reduce Adverse Childhood Experiences by investing in prevention efforts. This type of alignment and leveraging will be a key component of the Collaborative development.

BHT Value-Based Payment Strategies

BHT has provided multiple opportunities for partners to learn about VBP, including quarterly updates at the ACH Leadership Council and the BHT Board meetings. Mark Wakai of Providence Health Services, who sits on the MVP team, gave a presentation on the VBP Roadmap to our Regional Integration Team on September 12, 2017 and to our Leadership Council on September 28, 2017. In October, the BHT ACH hosted a Learning Session conducted by HCA's Chief Medical Officer, Dr. Dan Lessler that touched on the intersections between Bi-Directional Integration and VBP. We have reached more than 100 organizations via these efforts. BHT has consistently prioritized VBP education and strategy development as a key element in achieving MTD goals.

Describe how the ACH supported and/or promoted the distribution of the 2017 Provider VBP Survey

BHT ACH distributed the 2017 Provider VBP Survey first via its weekly partner email, which was sent to 291 recipients. The survey link was also placed on the front page of our BHT's website for the months of July and August, during which time the page had a total of 1,811 views.

15 organizations responded to the 2017 Provider VBP Survey. Respondents represent Medicaid-critical providers in the region (e.g. CHAS; Lake Roosevelt CHC; Providence; MultiCare; Ferry, Lincoln, and Newport Hospital districts). Providers responding represent a good cross section of partners, including Tribal health, behavioral health, inpatient/outpatient facilities, critical access hospitals, hospitals, Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), multi-specialty practices, and not-for-profit organizations.

Describe the current state of VBP among the ACH's providers

The BHT ACH has worked hard to ensure that our health care and Social Determinant of Health partners are aware of the state's goal to move 90% of Medicaid payments to a Value Based model by 2021. Increasingly, our discussions are moving to specifics about readying providers to meet the goals. We are encouraged by the fact that 6 of the 15 respondents in the HCA VBP Survey reported that they currently have Medicaid Contracts that meet the VBP targets in the LAN categories 2C-4B. Additionally, the BHO in our region has been including Value Based

Payments in their provider contracts over the last few years. But even with these data points, we expect that there is a significant amount of work to be done to meet the 90% target in the region. The BHT ACH Rural and Spokane County Collaboratives will develop a provider-by-provider plan to prepare the region for VBP in partnership with the Managed Care Organizations and the Health Care Authority.

Has the ACH obtained additional information beyond what the survey included? If so, were these findings consistent or inconsistent with the survey results?

The ACH has informally discussed VBP contracts with MCOs and providers over the last few months and the survey findings are consistent. There is high level knowledge from regional Medicaid providers about VBP goals, the need for investment in clinical and HIE transformation to be ready for risk-based VBP contracts, and acceptance that VBP offers a strong value proposition to serve patients better. However, there is concern of inadequate access to services for mental health, substance use treatments and social determinants of health funding to adequately support whole person care. This may result in providers being less likely to assume risk based VBP contracts.

How do providers expect their participation in VBP to change in the next 12 months?

The 15 provider survey respondents indicated that:

- 1 would decrease VBP by 10%
- 3 would stay the same
- 5 would increase by up to 10%
- 3 would increase by 10-24%
- 3 would increase by 25-50%

For your partnering providers, what are the current barriers and enablers to VBP adoption that are driving change?

Among those with VBP experience, responses about what has supported (enabled) their participation in VBP were varied. The most frequently noted participation enablers were trusted partnerships and collaboration with payers, and aligned incentives and contract requirements.

Data issues were the most frequently mentioned barrier - 9 or 10 organizations cited these as obstacles:

- Lack of interoperable data systems
- Lack of access to comprehensive data on patient populations (e.g., demographics, morbidity data)
- Lack of availability of timely patient/population cost data to assist with financial management

- Access to mental health, substance use treatment, housing, transportation services

In our conversations, MCOs have referenced already-established VBP contracts and are moving toward meeting the Healthier WA 2017 milestone that 30% of Medicaid contracts be in VBP arrangements. Several of BHT ACH's key provider partners are likely to be in a position to move progressively from 50%-90% VBP within the Healthier WA established timeframes. The Collaboratives will develop a plan to support the majority of Medicaid providers in meeting the 90% VBP goal by the end of the MTD period.

Describe the regional strategies that will support the attainment of, and readiness to, achieve statewide VBP targets, including plans for the ACH to partner with MCOs and provider associations.

BHT ACH will support providers in the transition to VBP through a current state assessment to determine provider readiness. This assessment will validate and expand on data the state collected through its annual provider VBP survey. BHT ACH will also provide technical assistance support to providers to ensure readiness.

BHT ACH will provide VBP support to the Spokane and Rural Collaboratives in the form of financial incentives tied to project planning. Each provider and Collaborative will be required to identify a plan for reaching VBP goals.

BHT ACH will also make investments, through its Community Resiliency Fund, in the social determinants necessary to improve health status, e.g., transportation and food, to provide additional support for the achievement of VBP metrics and targets. BHT ACH is in a unique position to make investments in social determinants and strengthen the connections between social services and health care providers to support population health. Investments will be informed by gaps identified by health care and social services providers and through the Regional Health Needs Inventory.

BHT ACH will also support behavioral health providers to adopt EHRs and other population health IT tools (registries, data systems, billing systems) through technical assistance and training.

BHT ACH will continue to work with MCO partners on VBP alignment to ensure MCO contracts and ACH demonstration projects are aligned.

What will be the ACH's role in supporting providers in the transition to VBP arrangements? What are the preliminary considerations and strategies regarding alignment of VBP strategies in all projects?

BHT ACH will continue working with MCO partners to align/harmonize ACH metrics with MCO VBP contracted outcomes to facilitate and ease provider transition to VBP.

BHT ACH will conduct an FIMC assessment and provide TA to ensure that behavioral health providers have adequate EHR and health IT tools to share information with health care partners. BHT ACH is also considering providing contract negotiation support to behavioral health providers as they prepare for FIMC. This support would include a needs/gaps analysis in early 2018 so that any contracted implementation and funding models reflect needed infrastructure investments.

BHT ACH will also require that each Collaborative consider how project plan strategies contribute to the achievement of the VBP metrics/targets. Additionally, each Collaborative and participating provider will be required to make a commitment to meet VBP targets.

BHT ACH will support ACO development in rural communities, and align efforts and resources to comply with state VBP goals and MACRA and MIPS targets.

BHT Workforce Strategies

Growing and maintaining the supply of behavioral health professionals is a priority for the BHT ACH, given its focus across project areas on improving access and care for individuals with behavioral health and co-occurring conditions. Similarly, establishing a strong network of care coordinators (whether those are Community Health Workers (CHWs), Medical Assistants (MAs), or Peer Counselors) will support Pathways and other bi-directional integration work. Currently, most of the BHT ACH region is designated as a mental health care professional shortage area,^{li} and BHT ACH area participants in the Washington State Health Workforce Sentinel Network report recent increases in demand for clinical social workers and mental health counselors.^{lii}

Partners who participated in the BHT ACH Health Systems Inventory noted long-standing challenges with workforce recruitment and retention across a variety of roles. A more focused workforce assessment linked to developing MTD implementation plans will be conducted in Q1 2018 with Collaborative partners. The BHT ACH will partner with the Community Colleges of Spokane and the regional Workforce Development Council to complete the assessment, with a special focus on building capacity for the next generation of health workforce that will meet the needs of a transformed community health system.

Partner discussions have enabled us to determine initial focus areas for further development through the assessment:

- Assess care coordination utilization and capacity in clinic and community based organizations.

- Explore credentialing requirements for Care Coordinators include Health Coaches, Health Homes Care Coordinators and other Community Health workers
- Explore Community Paramedicine opportunities to increase the use of volunteer EMS staff to serve as a bridge between the patient and care coordination.
- Explore potential use of Medical Assistants as members of integrated primary care teams, an identified gap area priority of our rural partners. As the rural population ages and access to services continues to be a challenge, the exploration of the addition of MAs as “health extenders” is warranted.
- Assess mental health and substance use workforce gaps
 - Explore opportunities to increase the pipeline for mental health and substance use providers. Work with MCOs in the transition to FIMC to ensure the workforce capacity of BH providers in integrated settings
 - Utilization of TeleHealth and TelePsychiatry in rural and primary care settings
- At the Collaborative level, assess training needs to support providers who practice in an integrated, value-based system

How BHT ACH is considering and prioritizing statewide workforce capacity development

As we develop a regional workforce strategy to meet MTD project and Collaborative needs, we will align our efforts with other regional strategies. These include: increasing the number of Primary Care Residency slots for Graduate Medical Education; expanding the rural track in the UW Primary Care Residency program; developing a Psychiatry Residency program, to further integrate a whole person team approach at WSU’s Medical School; and launching the Providence Dental Residency Clinic.

We are also partnering on workforce innovations with the Spokane Area Workforce Development Council and Greater Spokane Incorporated (GSI), the largest regional business organization in the area. GSI is focused on creating an environment where employers can succeed, compete, and grow. GSI’s “Vision 2030” includes growing a Health and Life Sciences Industry and increasing education attainment from 40% to 60% by 2025.

Finally, we are participating in conversations with other ACHs, HCA, DOH, Washington State Hospital Association (WSHA), Washington State Medical Association (WSMA), and the University of Washington Center for Health Workforce Studies to align our local strategy with statewide efforts.

Please provide additional details on how the ACH plans to use the current workforce initiatives and resources as the ACH continues to plan for workforce strategies.

BHT ACH will make available resources and information from the partnerships listed above to

Collaboratives to help them with their planning. BHT will also work closely with state partners and other ACHs to develop a robust short term strategy to meet the needs of our local providers to increase capacity.

BHT supports the regional approach to provider capacity and has actively engaged leadership from key partners in our ACH Leadership efforts. These leaders are focused on expanding workforce in new regional residency and training programs. We are excited to not only leverage the “on the job” training residencies provide as an expansion to our delivery system access efforts, but also the opportunity to long term effect the curriculum development that focuses on whole person, culturally relevant, patient-centered, team-based care.

Through the development of the ACH our rural partners have consistently stated the need to expand capacity through robust utilization of telehealth strategies. The BHT ACH expects to invest via our regional infrastructure funds to extend the utilization of telehealth strategies, specifically to increase behavioral health access. The NW Rural Health Network, whose members include the public hospital districts in our area, is currently soliciting an RFP for a shared resources across the region.

BHT has deep involvement with the Eastern Washington Community Health Worker Network. A BHT staff member participates regularly as part the Network Leadership Committee and provides updates on Medicaid Transformation project development. BHT staff also provide capacity to support CHW workforce development within the Network through recruiting for CHW training and coordinating supplemental training opportunities. In conjunction with the Foundation for Healthy Generations, BHT provided an “ACH 101” and overview of the Pathways Hub Model on October 12, 2017 to over 50 CHWs. This presentation was met with enthusiasm and eagerness to support regional adoption of Pathways. Marion Lee, the coordinator of the Network and Trainer for the DOH CHW program, has accepted an invitation to co-chair the BHT Community Voices Council. Her role as Network coordinator and standing in the community as an advocate for the population that CHW’s serve is an excellent fit for stakeholder engagement and community buy-in for MTD project development.

In planning workforce strategies for FIMC and MTD, BHT ACH’s intent and expectation is that the Collaboratives will retain and expand the current behavioral health workforce capacity. The BHT ACH expects to invest in tools to support this effort. To assist with the development of the strategy, BHT ACH will require each Collaborative to develop a plan to address provider shortages and set goals to increase capacity.

BHT Population Health Management Systems

Thirty-nine unique organizations in the BHT ACH region completed a Health Systems Inventory (HSI) or Care Coordination Inventory (CCI) to help the BHT ACH learn more about the organizations' patients and work in areas relevant to the MTD.

Based on provider responses to the HSI, we know that multiple data systems are in use across the community. It will be necessary to conduct a provider/Collaborative-level assessment on HIE/HIT. We will conduct an HIE/HIT survey in Q1 2018 to better understand systems and tools in use. This will include mapping assets and current population health management systems capabilities, capacity and gaps and develop a plan for creating the necessary interconnectivity across providers.

The BHT ACH will develop a regional implementation plan to ensure a coordinated, leveraged, and cost-effective solution. We expect to explore a robust partnership with OneHealthPort and other state initiatives.

The BHT ACH has developed the following strategies to expand, use, support, and maintain population health management systems across all projects:

- Use the Collaborative structure to incent shared accountability tied to outcomes for population health. It is expected that each Collaborative will be eligible for payments based on performance on HIE/HIT adoption.
- BHT has subcontracted with Providence CORE to create a community dashboard that will a) provide a broader view of community health; b) help inform community resiliency investing (another eligible earned incentive category under BHT's approach); and c) connect information about social determinants and clinical care.
- Utilize FIMC Incentives to support providers for connectivity and upgrade EHRs to meet integrated care reporting and billing needs. Each Collaborative will assess needs/gaps that will inform the Waiver Finance Workgroup recommendations to the BHT Board on levels of investment.
- Explore information sharing and strategy development with the Washington State Hospital Association (WSHA). BHT's ED has actively engaged with WSHA about capacity and potential utilization of adapting WSHA's current hospital data reporting system to include population health information.

Endnotes

-
- ¹ See: http://www.doh.wa.gov/Portals/1/Documents/2900/wa_ach_od_quarterly_2017Q1.zip
- ² See: <https://www.doh.wa.gov/DataandStatisticalReports/DiseasesandChronicConditions/ChronicDiseaseProfiles/AccountableCommunitiesofHealth>
- ³ Washington State Office of Financial Management (2017). *Potentially Preventable Hospitalizations by Legislative District*. Research Brief No. 85. Available at: <http://www.ofm.wa.gov/researchbriefs/2017/brief085.pdf>
- ⁴ Coordinated Care, Molina, and United submitted CCI; these 3 MCOs represent 73% of the enrolled population based on HCA Medicaid Enrollment reports (Plan by Program) for September 2017. See: <https://www.hca.wa.gov/about-hca/apple-health-medicaid-reports>
- ⁵ HCA ACH Toolkit Provider Report Files updated 09.01.17, see: <https://wahca.app.box.com/s/mxpg8euzbjpdkmyuftzb4ri5v41ia8v9/folder/30748038709>.
- ⁶ Spokane Regional Health District Data Center (2017). Community Linkage Mapping: General Report. An assessment of the regional population and social determinants of health systems. See: <https://goo.gl/1WDBpo>. See also the interactive map available at: <http://arcg.is/2pH9kuT>
- ⁷ Calculations using Washington State Office of Financial Management Official Population Estimates for 2016; see: <http://www.ofm.wa.gov/pop/april1/>
- ⁸ Based on 2010 census data and RUCA designations by Washington State Office of Rural Health; see: ftp://ftp.doh.wa.gov/geodata/layers/Scheme4_rurality_censustracts_WA.pdf
- ⁹ Healthier Washington Data Dashboard, CY 2016 data: <https://www.hca.wa.gov/about-hca/healthier-washington/data-dashboard>
- ¹⁰ Healthier Washington Data Dashboard (CY 2016) and Office of Financial Management small area population estimates for 2016.
- ¹¹ Healthier Washington Data Dashboard, Oct. 2015 – Sept. 2016 data
- ¹² Based on Office of Financial Management small area population estimates, change in Hispanic population 2010-2016. See: <http://www.ofm.wa.gov/pop/asr/>
- ¹³ Healthier Washington Data Dashboard, CY 2016 data: <https://www.hca.wa.gov/about-hca/healthier-washington/data-dashboard>
- ¹⁴ Spokane Area Workforce Development Council, see: http://www.betterhealthtogether.org/s/BetterHealthTogether_final.pdf
- ¹⁵ Based on 2015 data, RWJF County Health Rankings: <http://www.countyhealthrankings.org/>
- ¹⁶ Urban Indian Health Institute, Seattle Indian Health Board. (2017). *Community Health Profile: Individual Site Report, Spokane Urban Indian Health Program Service Area*. Seattle, WA: Urban Indian Health Institute. Note that these estimates are based on 2010-14 American Community Survey data, while the RWJF County Health Rankings employment measure uses the Current Employment Statistics Survey.
- ¹⁷ See: <http://www.commerce.wa.gov/housing-needs-assessment>. Affordable (meaning they cost less than 30% of average household income) & available units per 100 households in BHT ACH counties are: Adams 22, Ferry 26, Lincoln 22, Pend Oreille 26, Spokane Co. 12, Stevens 26. Spokane metro area has 14 affordable & available housing units per 100 households.
- ¹⁸ BHT ACH Health Systems Inventory (2017).
- ¹⁹ HCA ACH Toolkit Historical Data: <https://wahca.app.box.com/s/mxpg8euzbjpdkmyuftzb4ri5v41ia8v9/folder/36950052036>
- ²⁰ HCA Co-occurring disorder tables, see: <https://wahca.app.box.com/s/mxpg8euzbjpdkmyuftzb4ri5v41ia8v9/folder/39866406519>
- ²¹ HCA hospitalizations_ach_rhni_tables: <https://wahca.app.box.com/s/mxpg8euzbjpdkmyuftzb4ri5v41ia8v9/folder/23928005433>. (Note that 1/3 of
-

-
- [Medicaid-paid hospitalizations in BHT's region that were not related to pregnancy/childbirth were classified as stemming from "other causes" in the available data](#)
- ²² BHT ACH Health Systems Inventory (2017).
- ²³ HCA RHNI "starter set" files, see:
<https://wahca.app.box.com/s/mxpg8euzbjpdkmyuftzb4ri5v41ia8v9/folder/23928005433>
- ²⁴ Washington Prescription Drug Monitoring Program, see:
<https://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/HealthcareProfessionsandFacilities/PrescriptionMonitoringProgramPMP/CountyProfiles>
- ²⁵ HCA ACH Toolkit Historical Data:
<https://wahca.app.box.com/s/mxpg8euzbjpdkmyuftzb4ri5v41ia8v9/folder/36950052036>
- ²⁶ HCA ACH Toolkit Historical Data:
<https://wahca.app.box.com/s/mxpg8euzbjpdkmyuftzb4ri5v41ia8v9/folder/36950052036>
- ²⁷ Healthier Washington Data Dashboard, CY 2016 data: <https://www.hca.wa.gov/about-hca/healthier-washington/data-dashboard>
- ²⁸ Healthier Washington Data Dashboard, Oct. 2015 – Sept. 2016 data
- ²⁹ HCA Medicaid enrollment reports; see: <https://www.hca.wa.gov/about-hca/apple-health-medicaid-reports>
- ³⁰ Data are from 2012 or 2013 and only available for Adams, Lincoln, Spokane, and Stevens counties. Based on surveys of licensed providers conducted by the Washington State Department of Health, Office of Rural Health, see:
<https://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/RuralHealth/DataandOtherResources/HealthProfessionalShortageAreas/HealthcareAccessReports>
- ³¹ Spokane Regional Health District Data Center (2017). Community Linkage Mapping: General Report. An assessment of the regional population and social determinants of health systems. See: <https://goo.gl/1WDBpo>. See also the interactive map available at: <http://arcc.is/2pH9kuT>
- ³² The transitional respite care program was featured in a recent RWJF case study, available here:
http://www.chcs.org/media/Respite-Program-Case-Study_101217.pdf
- ³³ Healthier Washington Data Dashboard, Oct. 2015 – Sept. 2016 data
- ³⁴ Healthier Washington Data Dashboard, CY 2016 data: <https://www.hca.wa.gov/about-hca/healthier-washington/data-dashboard>
- ³⁵ Qualis Health (December 2016). *2016 Regional Analysis Report, Washington Apple Health, Washington Health Care Authority*. Available at: <https://www.hca.wa.gov/assets/program/eqr-regional-analysis-report-2016.pdf>
- ³⁶ Healthier Washington Data Dashboard, CY 2016 data: <https://www.hca.wa.gov/about-hca/healthier-washington/data-dashboard>
- ³⁷ Healthier Washington Data Dashboard, Oct. 2015 – Sept. 2016 data
- ³⁸ HCA ACH Toolkit Historical Data:
<https://wahca.app.box.com/s/mxpg8euzbjpdkmyuftzb4ri5v41ia8v9/folder/36950052036>
- ³⁹ Washington State Department of Health, Office of Rural Health, see:
<https://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/RuralHealth/DataandOtherResources/HealthProfessionalShortageAreas>
- ⁴⁰ Skillman SM, Dahal A. (2017). *Washington State's Physician Workforce in 2016*. Seattle, WA: Center for Health Workforce Studies, University of Washington.
- ⁴¹ Washington State Health Workforce Sentinel Network data for April-May 2017 reporting period. 13 total respondents for the BHT ACH region, among which 4 and 3 reported demand increases for social workers and counselors, respectively. See: <http://www.wtb.wa.gov/HealthSentinel/>
- ⁴² Qualis Health and Washington State Health Care Authority. (2016). Apple Health Managed Care CAHPS® 5.0H Adult Medicaid report. See: <https://www.hca.wa.gov/assets/program/ahmc-overall.pdf>
- ⁴³ HCA ACH Toolkit Historical Data:
<https://wahca.app.box.com/s/mxpg8euzbjpdkmyuftzb4ri5v41ia8v9/folder/36950052036>
- ⁴⁴ Washington State Office of Financial Management (2017). Potentially Preventable Hospitalizations by Legislative District. Research Brief No. 85. Available at: <http://www.ofm.wa.gov/researchbriefs/2017/brief085.pdf>
- ⁴⁵ BHT ACH Health Systems Inventory (2017).
-

-
- ⁴⁶ Washington State Department of Health, Center for Health Statistics, 2009-2013. Calculations and presentation of data by Spokane Regional Health District, Data Center.
- ⁴⁷ 2013 Foster Placement rate per 1000. Spokane County = 10.2, state average = 5.7.
(<http://datacenter.kidscount.org/data/>)
- ⁴⁸ 2016 Washington Healthy Youth Survey data for BHT region, grades 6, 8, and 10 (grade 12 response rate too low to include). See: <http://www.askhys.net/library/2016/ACH01MultiGr.pdf>
- ⁴⁹ RWJF County Health Rankings, based on 3 years of pooled BRFSS data.
See: <http://www.countyhealthrankings.org/app/washington/2017/measure/outcomes/60/data>
- ⁵⁰ Felitti V, et al. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. *Am J Prev Med.* 14(4):245–258
- ^{li} Washington State Department of Health, Office of Rural Health, see:
<https://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/RuralHealth/DataandOtherResources/HealthProfessionalShortageAreas>
- ^{lii} Washington State Health Workforce Sentinel Network data for April-May 2017 reporting period. 13 total respondents for the BHT region, among which 4 and 3 reported demand increases for social workers and counselors, respectively. See: <http://www.wtb.wa.gov/HealthSentinel/>

SECTION II: PROJECT-LEVEL

Transformation Project Description

Select the project from the menu below and complete the Section II questions for that project.

Menu of Transformation Projects	
Domain 2: Care Delivery Redesign	
X	2A: Bi-Directional Integration of Physical and Behavioral Health through Care Transformation (required)

Project Selection & Expected Outcomes

The scope of the project may be preliminary and subject to further refinement. In Demonstration Year 2, the ACH will be required to finalize selections of target population and evidence-based approaches, and secure commitments from partnering providers.

ACH Response

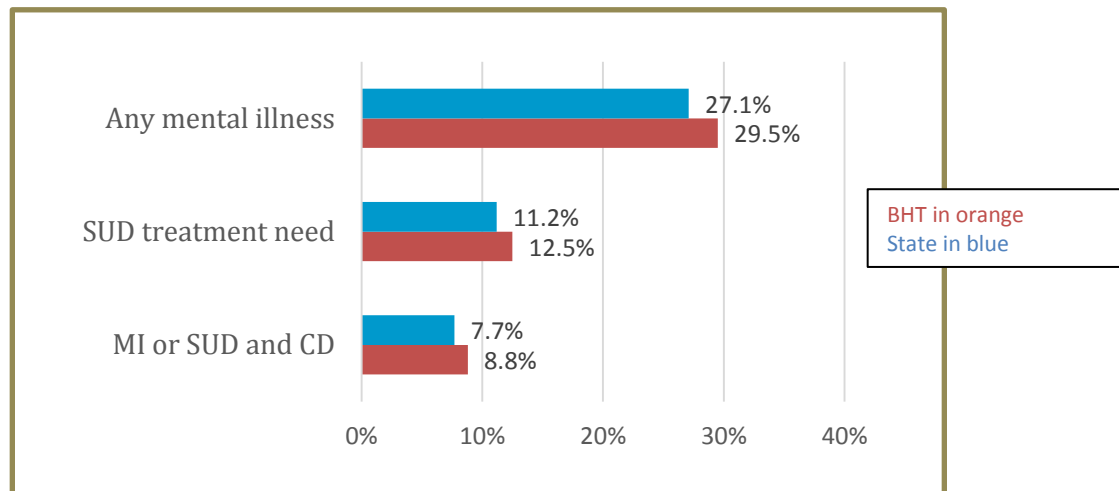
Project Description and Justification

In 2017, BHT launched a cross-sector discussion with Behavioral Health, Physical Health, Managed Care Organizations and County Commissioners around the opportunities tied to fully-integrated managed care (FIMC). This discussion changed the tenor of the discussion in the region from behavioral health provider concerns about the unintended consequences of change to a consideration of broad system transformation opportunities through new investments, with the possibility of reduced costs and improved population health. As a result, our community committed to bi-directional integration as a cornerstone of our community health transformation efforts.

The BHT ACH bi-directional integration project is designed to improve whole-person care and health outcomes by encouraging and facilitating evidence-based models of care for high-needs populations, while also building on existing physical and behavioral health integration activities. Consistent with the Medicaid Transformation Demonstration (MTD) Project toolkit guidance, BHT will support clinics in the implementation of evidence-based models such as the Bree Collaborative or the Collaborative Care Model, and will leverage Health Information Technology and care coordination infrastructure to launch our integration efforts. Furthering integration of physical and behavioral health care is a critical step in addressing the health needs of the regional population. This initiative holds promise to enhance care coordination across the spectrum of physical and behavioral health conditions, and offer patients more timely access to essential services.

More than 44,000 BHT ACH Medicaid members have been diagnosed with a mental illness, and the prevalence of mental illness is 29.5% in the BHT ACH region, higher than the statewide level. Approximately 20,000 clients in the BHT ACH region have a substance abuse treatment need, equating to a prevalence of 11.2%. Finally, and perhaps most concerning: about 36,000 have a mental health **or** substance abuse condition **and** 1 or more chronic disease, indicating a high level of need for bi-directional care integration to provide whole person care and navigate the many obstacles that arise for patients suffering from these conditions.¹ Figure 1 below provides details on the prevalence of conditions in the BHT region (orange) compared to the statewide prevalence rate (blue).

Figure 1: Proportion of Medicaid Population with Key Conditions



Justification for selecting project and how it addresses regional priorities

The prevalence of behavioral health disorders and substance use disorders (SUD) constitutes a major public health issue in the BHT ACH region. Outside of pregnancy and childbirth, ‘mental and behavioral disorders’ were the leading cause of hospitalization for BHT ACH Medicaid beneficiaries in 2015, accounting for 17.5% of all non-birth-related hospitalizations. Substance abuse disorders accounted for 5.7% of such hospitalizations overall but 8% among non-disabled adults. (Note that 1/3 of Medicaid-paid hospitalizations in the BHT ACH region that were not related to pregnancy/childbirth were classified as stemming from “other causes” in the available data.)²

Moreover, opioid use is high among the BHT ACH Medicaid population. 17.4% of BHT ACH Medicaid beneficiaries are current opioid users, vs. 13.5% statewide, and 3.6% are heavy users.³ In almost all of the BHT ACH counties, opioid prescriptions are written and filled at a higher rate than average for Washington state (Adams County is the exception).⁴ The BHT ACH exceeds the state average for Medicaid users receiving medication-assisted treatment with buprenorphine (11% vs. 10% statewide) but is substantially below the state average for methadone MAT (11% vs. 16% statewide).⁵

The BHT ACH is a little below the state average for mental health treatment and substance abuse treatment penetration rates among Medicaid beneficiaries. On the other hand, rates of follow-up after a hospitalization or ED visit related to mental health or substance use are higher than the average for Washington State.⁵

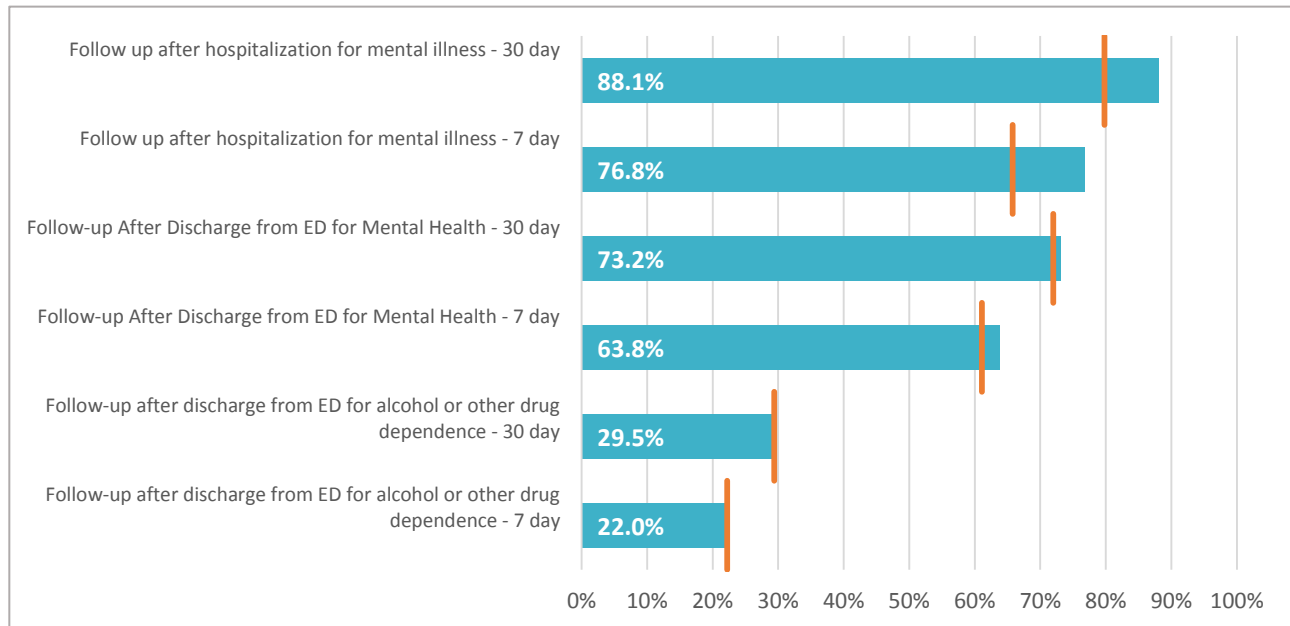
Overall, estimated chronic disease prevalence among the Medicaid population in the BHT ACH region is close to the statewide figures: approximately 3% had an inpatient or outpatient claim in the last year that included a diagnosis of diabetes (vs. 4% statewide) and 5% had a claim with a diagnosis of asthma (vs. 4% statewide). However, these figures mask some regional variation:

- Asthma is higher than the state average in Stevens County (6%) and Ferry and Spokane Counties (5%).
- Smoking is a risk factor for a number of chronic diseases and BHT has some of the highest (Stevens County at 33%) and lowest (Adams County at 8%) smoking rates among Washington’s Medicaid beneficiaries.

- Depression diagnoses among Spokane County Medicaid recipients is 12% but Adams County has the lowest rate in the state at 3%.⁶

Finally, while the BHT ACH region currently performs at or above the state level on several performance measures that are connected to the 2A project, there are still promising opportunities to enhance integrated care, such as increasing follow-up after discharge from the ED for encounters tied to a mental health conditions. These opportunities for improved processes and patient outcomes provide a key rationale for this investment.

Figure 2: BHT performance on select integration performance measures⁷



How project will support sustainable health system transformation for the target population

Transforming the healthcare system to be more responsive to the needs of people receiving Medicaid services through the provision of integrated care, whether in a primary care or behavioral health clinic, will improve outcomes not only for the 2A target population, but for Medicaid beneficiaries overall. We will scale up to full implementation over the course of the MTD period, starting with the high-risk population of Medicaid enrollees with co-morbid conditions in order to be successful in achieving expected project outcomes. It is the expectation that by increasing integrated care to this target populations, there will be gains to the entire healthcare delivery system. As providers become more fluent in collaborating in patients' care, whole-person care, expected results include earlier diagnosis, treatment, and opportunities to move care upstream and prevent conditions from exacerbating and becoming chronic.

In addition to stronger integration of care between physical and behavioral health providers, collaboration with social service providers through the Pathways Hub model implementation will lay the groundwork for providers to effectively address social determinants of health, which, left unaddressed, contribute to poor health outcomes. Lastly, we are exploring telehealth options to increase access to care. Our provider network is currently reviewing potential tele-behavioral health services, which would be available for emergency consults in the ED, for medication management and support of the primary care team, and for ongoing care of individuals with chronic behavioral health issues. Some examples already exist that could be taken to scale: health systems are working with specialists in Spokane to have follow-up visits done via telehealth; Lincoln County has used a telehealth-based hospitalist program; Newport has diabetes

education classes delivered via telehealth; and there is also a regular Parkinson's Disease support group that meets regularly around the region via telehealth.

How Better Health Together will ensure project coordinates with and doesn't duplicate existing efforts

Better Health Together is supporting the development of two Community Health Transformation Collaboratives:

1. Rural Collaborative (comprised of Ferry, Pend Oreille, Stevens, Lincoln, and Adams counties)
2. Spokane Collaborative (Spokane County).

The BHT ACH is taking a regional approach to project design and implementation that will provide local autonomy and regional accountability. The Collaboratives will be responsible for developing and implementing actionable MTD plans across BHT's project portfolio, and ensuring that the projects coordinate with each other and do not duplicate existing efforts in the region. The Collaboratives will be comprised of key partners with the expertise and experience required to transform our Medicaid Delivery System including clinics, Federally Qualified Health Centers (FQHCs), Hospitals, Mental health and Substance Use providers, Public Health, Tribal Health systems, EMS, Jails and County Commissioners. This representation will ensure efforts are coordinated across the region and resources are leveraged.

Anticipated Project Scope

Anticipated target population

The Medicaid Demonstration Toolkit suggests an overall target population of all the Medicaid enrollees in the region, approximately 196,000 individuals in the BHT region. 2A's ultimate project goal for the demonstration is full implementation of integrated care for all Medicaid beneficiaries. We are proposing to scale up to full implementation, starting with a high-risk population of Medicaid enrollees with co-morbid conditions, in order to be successful in achieving expected project outcomes.

An estimated 36,000 Medicaid beneficiaries in the BHT region have a mental health or substance use disorder and one or more chronic diseases. However, there are a few subpopulations within the broader BHT Medicaid population that are at higher risk of suffering from substance use disorder (SUD), mental health (MH) conditions, and chronic diseases, or a combination thereof. As shown in Table 2, disabled clients and newly eligible (Medicaid expansion) adults in the Medicaid population have a higher rate of co-occurring disorders than the traditional Medicaid population. Rates are also higher than expected in Pend Oreille and Spokane counties.⁸ In the BHT ACH region, people with an MH and SUD diagnosis are almost 5 times as likely to have 3+ ED visits in a year as general BHT ACH area Medicaid beneficiaries.⁹

Table 3: Co-occurring conditions by Medicaid eligibility group in the BHT ACH region⁸

Coverage group	SUD	MH condition	Chronic Disease	SUD or MH and CD
Disabled	27.7%	60.6%	24.6%	58.8%
New adults (Medicaid Expansion)	20.3%	32.1%	24.2%	29.4%
Traditional Medicaid	5.5%	20.4%	27.2%	13.4%

We will work initially with the highest volume providers in each county to further target our efforts within the group of 36,000 individuals with co-occurring conditions. For example, we will look for opportunities to connect bi-directional integration strategies with our diabetes-focused chronic disease efforts for the estimated 4,850 members who have diabetes as well as a mental health or substance abuse disorder.

Involvement of Partnering Providers

To develop the proposed project, the BHT ACH convened and met one-on-one with high volume and engaged partnering providers throughout the region working on physical and behavioral health integration. In addition, the BHT ACH engaged providers a Health Systems Inventory and a Care Coordination Inventory, to identify provider interest in MTD project areas. Draft inventories were first released for public feedback, and once launched, we hosted 3 webinars to overview the Inventory and answer any questions from partners. BHT staff hosted 15 hours of Office Hours sessions where partners could drop in and talk with ACH staff about their Inventories or MTD, in addition to numerous outreach meetings to individual provider organizations. Through these efforts, BHT has engaged a broad range of providers critical to the success of bi-directional integration project, including physical and behavioral health providers, county providers, social service agencies and MCOs.

39 organizations in the BHT ACH region, representing most major health and social service systems, completed the Health Systems Inventory (HSI) and/or Care Coordination Inventory (CCI). These efforts directly informed the development of the proposed Bi-Directional Integration project priorities and the BHT ACH proposal to develop regional Collaboratives to implement MTD projects. The following Health Systems partners indicated interest in serving as partnering providers on a bi-directional integration project within their settings:

- American Indian Community Center
- Columbia Basin Health Association
- CHAS Health
- East Adams Health Care
- Excelsior Youth Center
- Frontier Behavioral Health
- Lake Roosevelt Community Health Centers
- Lincoln Hospital and Clinics
- NATIVE Project
- Northeast Tri-County Health District
- Northeast Washington Alliance Counseling Services
- Newport Hospital and Health Services
- Lincoln County Public Hospital District 1 d/b/a Odessa Memorial Healthcare Center
- Planned Parenthood
- Providence Health Care
- Rockwood Clinic, MultiCare Health System
- Spokane Regional Health District
- Spokane Treatment and Recovery Services
- Yakima Valley Farm Workers Clinic

Additionally, the following organizations expressed interest in supporting this MTD project through our open Letter of Interest process:

Provider/Partnering Organization	LOI for Project Implementation	LOI for Project Partnership
Aging and Long-Term Care of Eastern Washington	X	X
Catholic Charities Spokane		X
CHAS Health	X	
Communities in Schools		X
Consistent Care Services, SPC, PS	X	
Community Health Plan of Washington		X
East Adams Rural Healthcare	X	
Ferry County Public Hospital District	X	X
Empire Health Foundation	X	
Frontier Behavioral Health	X	
Greater Spokane County Meals on Wheels		X
Inland Northwest Health Services	X	
Kalispel Tribe of Indians	X	
Lake Roosevelt Community Health Centers		X
Lincoln County Health Department	X	
Merit Disability		X
National Alliance on Mental Illness		X
NHHS/ Pend Oreille Health Coalition		X
Northeast Tri County Health District	X	X
Odessa Memorial Healthcare Center	X	
Operation Healthy Family	X	X
Oral Healthcare LLC	X	
Othello Community Hospital	X	
Pend Oreille Health Coalition	X	
Pioneer Human Services	X	X
Planned Parenthood		X
Providence Health Care	X	X
Rural Resources Community Action	X	X
SNAP		X
Spokane Neighborhood Action Partners	X	
Spokane Regional Health District	X	X
Virginia Matheny	X	
Washington Dental Service Foundation	X	X
YMCA		X
YWCA	X	

Level of Impact

Integrating services for all Medicaid beneficiaries across the BHT ACH region will result in better care and patient satisfaction, as well as cost efficiencies. The impact of the project will reach beyond the Medicaid beneficiaries in the region, with significant infrastructure improvements: Virtual integration and co-location methods, e.g.

- Behavioral health consultants with warm handoff (co-location)
- In-clinic BH providers (master's level) with remote support from psychiatrist (virtual & in person)
- In physical health setting: In-clinic BH providers (master's level) with remote support from psychiatrist (virtual & in person)
- In BH setting: More chronic disease management or self-management support

- Multidisciplinary teams
- Comprehensive shared care plans
- BH and chronic disease screenings

How Better Health Together will ensure that health equity is addressed in the project design

The Better Health Together Accountable Community of Health is ensuring that health equity is embedded in the project design at multiple levels:

- *Regional Health Transformation Collaboratives:* With the creation of distinct Spokane County and Rural Collaboratives, BHT is ensuring attention and focus to rural health issues and disparities in our region. In addition, we are designing these Collaboratives to include organizations that bring diverse racial and cultural perspectives to key regional health issues.
- *Community Voices Council:* BHT ACH is launching a Community Voices Council, made up of at least 50% Medicaid beneficiaries or low-income community members, to empower and bring consumer voices to inform project design and implementation. This Council will be tasked with developing health equity metrics by which to hold the Collaboratives and projects accountable to defined health equity goals and standards.
- *Target populations:* BHT is focusing projects on target populations experiencing the greatest health disparities. We are applying an “equity lens” to all our work by disaggregating data by race/age/ethnicity/sex/zip code wherever possible, both to make informed decisions about target populations and to monitor impact of projects across diverse groups. The BHT ACH will supply Collaboratives with regional data to guide early assessments of Collaborative partners, and will direct these teams to identify populations within their county that face a high level of disparities and/or present as highly complex or high risk. Initial data exploration indicates that individuals with co-occurring mental health and substance abuse disorders—who represent part of the initial focus population for our integration work—experience the following disparities in quality of care:¹⁰
 - Higher rates of general hospital readmissions (all-cause, 30 day)
 - Higher rates of readmission to inpatient psychiatric care (30 day)
 - Lower rates of annual HbA1c testing
- *Lived experience:* With the Community-based Care Coordination project, BHT ACH is advancing the Pathways model and use of Community Health Workers with lived experience of health inequities to further our efforts. Care coordinators are critical to developing trust and culturally-appropriate strategies to meet the needs of our target populations across the MTD project areas.
- *Equity Accelerator Payment:* We anticipate implementing this incentive to support providers who serve a greater proportion of high-risk clients. The metrics tied to these payments will be determined by the Waiver Finance Workgroup, vetted by Provider Champions Council and Community Voices Council, finalized by Waiver Finance Workgroup, and recommended to the BHT Board.
- *Pathways Community Hub Model:* Health equity is built into many elements of our Community-based Care Coordination strategy and the Pathways model, through individualized care plans; standards of care and access to the entire network of care agencies partnering with the Hub; culturally-informed care; and data infrastructure tools that can be used to monitor care practice, provider quality, and resource gaps in the community, to inform an accurate picture of our health system’s capacity.

Project’s lasting impacts and benefit to the region’s overall Medicaid population

Shifting to whole-person, integrated care will improve the quality of care people receive and improve outcomes for the most vulnerable populations and all Medicaid beneficiaries. This shift will also allow for a more efficient use of dollars, freeing up funds for increased investments in upstream health, including

population health, prevention and addressing social determinants of health. Infrastructure investments and clinical care redesign will be among the lasting impacts for the region's overall Medicaid population, including investments in HIE/HIT and workforce to support integrated care, established pathways for providers to develop new evidence-based models of care/proof of evidence, implementation of clinical screening tools to new populations, and facilitated/shared learning across collaborative providers. These investments will pave the way for lasting change in health care delivery and prepare providers in the BHT region for value-based payment.

Implementation Approach and Timing

See Supplemental Workbook

Partnering Providers

See Supplemental Workbook

ACH Response

How Better Health Together has included partnering providers that collectively serve a significant portion of the Medicaid population

As referenced above, the BHT ACH surveyed organizations in the region to complete a Health Systems Inventory (HSI) and/or Care Coordination Inventory (CCI) to gather provider information about existing work in the region related to the MTD project areas. BHT ACH received responses from 39 organizations, including hospital networks, provider systems, FQHCs, MCOs, and care coordination agencies.

Responding providers for the Health Systems Inventory represented more than 80% of the highest (top 10) volume Medicaid billers in primary care, mental health/substance abuse, inpatient and ED. For several settings in the BHT ACH's five rural counties, the HSI respondents represent *all* the Medicaid billers with claims or beneficiary counts of more than 10 in 2016.

Process for ensuring partnering providers commit to serving the Medicaid population.

In 2018, the BHT ACH will formalize partnering provider participation in the bi-directional project and other MTD project areas through a Transformation Compact process to ensure commitment to serving the Medicaid population. Through the ACH Leadership Council, Health System and Care Inventory, BHT ACH has a track record for engaging high volume providers in the region serving a significant portion of the Medicaid population. The BHT ACH has confidence they will commit to participation in the Collaborative and will formalize this commitment through the Transformation Compact.

Process for engaging partnering providers that are critical to the project's success, and ensuring that a broad spectrum of care and related social services is represented

BHT has identified that representation from the following sectors is required for Collaboratives to successfully implement projects:

- Physical Health Clinical Provider(s)
- Hospital System
- Behavioral Health Clinical Provider(s)
- Tribal Health System Providers

- Emergency Medical Services
- Criminal Justice
- SUD Provider(s)
- Community-Based Chronic Disease Prevention
- Community Based Care Coordinating Agency
- MCO(s)
- Crisis Management Services
- Liaison: Community Member/Consumer

Collaborative partnerships will be expanded as needed. In its role as the Pathways Hub, the ACH will serve as a connector between Collaborative providers and social and community partners. BHT ACH is also launching a Provider Champions Council to lend a practicing provider perspective to our work and to inform and validate Transformation Plans laid out by Collaboratives.

How Better Health Together is leveraging MCO's expertise in project implementation, and ensuring there is no duplication

Managed Care Organizations are actively involved in BHT's governance and leadership groups:

- Two MCO representatives, from Molina Health Care of Washington and Coordinated Care of Washington, are on the Board
- All five MCOs are voting members of BHT's Leadership Council and MCO staff participate in meetings and one-on-one sessions with the BHT team
- MCO representatives are on the BHT ACH Regional Integration Planning Team, Waiver Finance Workgroup, Provider Champions Council and Community Voices Council

MCOs will continue to participate in MTD project planning via these Technical Councils and through targeted collaboration with BHT ACH's Community Health Transformation Collaboratives.

In addition, BHT, Pierce County ACH, and Southwest ACH have collaborated on meetings with MCO partners to learn about key crossover areas between ACHs and MCOs under MTD, to ensure that the BHT ACH project strategy, support for providers/Domain 1 strategies, and monitoring and quality improvement efforts align with existing MCO activities and goals. Our discussions covered:

- Members/population overview
- PCP assignment/empanelment
- Provider support, particularly for value-based payment and related delivery system reform
- Measurement and quality improvement
- Member engagement/education
- Pathways

In the BHT ACH discussions with MCOs, it was emphasized the importance of considering the needs and utilization patterns of different Medicaid populations (e.g. expansion adults vs. traditional Medicaid) and designing strategies that can integrate additional groups (e.g. dual special needs clients) over time to fully engage MCOs and other partners and support sustainability. Another common point was the need to avoid overwhelming providers who are receiving assistance and requests for practice transformation efforts. The ACH and the Collaboratives can play a key role in coordinating TA support with MCOs. We also discussed ways to coordinate on data sharing with MCOs, HCA, the Washington Health Alliance, One Health Port and eventually the Washington All Payer Claims Database.

Regional Assets, Anticipated Challenges and Proposed Solutions

ACH Response

Assets Better Health Together and regional partnering providers will bring to the project:

The BHT ACH will utilize a rural and Spokane County Collaborative model to develop and implement actionable bi-directional integration plans. The Rural Collaborative, covering 35,173 Medicaid lives in the rural counties of Adams, Ferry, Lincoln, Pend Oreille and Stevens; and the Spokane County Collaborative, a county with 164,707 covered Medicaid. These Collaboratives are responsible for a local set of strategies to meet the MTD project goals. The Collaborative structure will align with the proposed MTD funds flow approach by allocating earned regional funds to each collaborative based on pay for reporting and pay for performance goal achievement. **Funds flow strategies** include plans for fixed and earned payments to both urban and rural provider partners to cover expenses such as project costs, project administration, provider engagement and participation, workforce development, population health management, and other costs.

In 2013, BHT developed the **Navigator Network**, a large and successful initiative to provide In-Person Assisters to enroll people in Apple Health (Medicaid) and Qualified Health Plans on the Washington Health Benefit Exchange. Through these efforts, BHT successfully enrolled over 125,000 people with health insurance (many of whom have behavioral health diagnoses) and developed a robust network of partners throughout the region. As the operator of the Navigator Network of Eastern Washington, BHT has direct connections with more than 50 organizations who host or employ navigators. This provides credibility and important local connections to providers needed to successfully implement our MTD projects.

Utilizing SIM funds, the BHT ACH piloted the **Pathways Hub Care Coordination** model to reduce jail recidivism rates in Ferry County. This project demonstrated the value of a common referral mechanism to address social determinants of health issues. For bi-directional integration, the Pathways Hub will provide added support to providers for referring high risk patients in need of social determinant of health support.

BHT and the NW Rural Health Network have worked collaboratively over the last 4 years to establish **Rural County Health Coalitions**. This has jump-started our planning to develop a county-based Collaborative model. In each of our 5 rural counties, there is an established structure that has engaged key stakeholders, including physical health clinical, hospital systems, behavioral health clinical, SUD, Community-Based Chronic Disease, Emergency Medical Services, Criminal Justice, Public Health and Community-Based Care Coordinating Agency providers. In Spokane County, through our Leadership Council, Community Strategy map workgroups, and the leveraging of additional networks, we have also identified key partners to serve as the foundation of the Spokane County Collaborative.

Other assets to be leveraged:

BHT ACH will explore a **partnership with Upstream USA**. Upstream delivers CME/CEU-eligible on-site training and technical assistance to health centers so they can remove barriers to same-day offering of the full range of contraceptive methods, including Long-Acting Reversible Contraceptives (LARC), to increase use of LARC and reduce unintended pregnancies. Upstream, in partnership with a large local funder, has identified Washington State as part of their expansion strategy. Investments could range

from \$1 million to \$50 million statewide.

BHT will explore a **partnership with the ARCORA Foundation, called Oral Health Connections**, to leverage investment in several oral health strategies. Based on the SBIRT model for behavioral health integration, this model reinforces advanced primary care, emphasizing team based care, EHR driven decision support, and coordinated referral to specialty care. Oral Health Connections is a system of care that connects Apple Health (Medicaid) patients with dental care in their local communities. In 2017, the Washington State Legislature mandated the Health Care Authority and ARCORA Foundation to work together to pilot Oral Health Connections in three communities (Spokane, Thurston, and Cowlitz Counties) with two target populations – patients with diabetes and pregnant women. Dentists serving these populations will receive enhanced reimbursements for doing so. Medical systems will identify, diagnose, and refer patients to dental care through an online referral tool, DentistLink, among other places. Medical and dental providers will share information and to develop shared plans of care. Patients in need of additional services will receive care coordination from local agencies. This is a key strategy for patient-centered integration of care, management of chronic diseases, and overall population health. The pilot is scheduled to launch on January 1, 2019.

Challenges to improving outcomes and lowering costs for target population and strategy to mitigate risks and overcome barriers:

<i>Challenges to improving outcomes</i>	<i>Strategies to mitigate risks/overcome barriers</i>
<ul style="list-style-type: none">• Training and TA for providers, including expectation setting for different groups and communication across professional cultures	<ul style="list-style-type: none">• Acting as a convener, BHT ACH will provide resources for provider training and TA support through the Collaborative structure
<ul style="list-style-type: none">• Harmonizing financial payment to PC and BH settings	<ul style="list-style-type: none">• BHT will work with HCA, MCOs, and the BHT ACH region to support education and adoption of VBP
<ul style="list-style-type: none">• Clarity and training around consent requirements and patient information sharing, incl. school-based health centers	<ul style="list-style-type: none">• Acting as a convener, BHT ACH will provide resources for provider training and TA support through the Collaborative structure
<ul style="list-style-type: none">• Workforce development, recruitment, and retention critical for MH - psychiatry and rural health, in particular. Both child and adult practitioners are needed.	<ul style="list-style-type: none">• BHT ACH will continue to work on regional workforce strategies with our WDC and education partners
<ul style="list-style-type: none">• Lack of telehealth infrastructure (technology, space) and staff training support	<ul style="list-style-type: none">• Explore regional contacting with telehealth technology providers to overcome issues with rural volume
<ul style="list-style-type: none">• Increasing access, utilization and attachment to PCP	<ul style="list-style-type: none">• Use of Collaborative infrastructure to develop provider-led strategies to increase access, utilization, and attachment to PCP

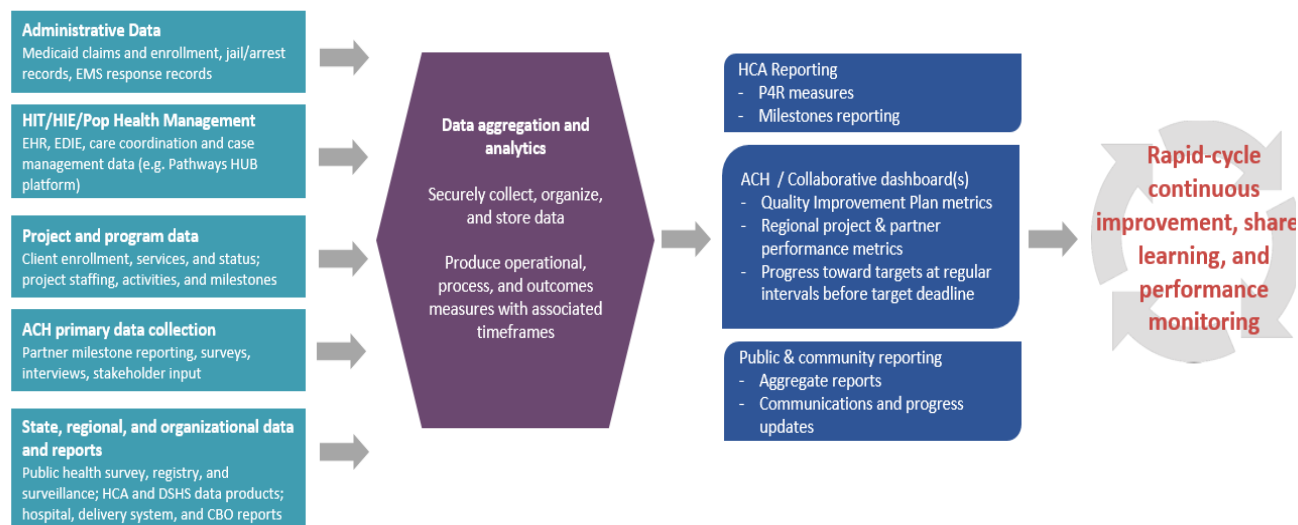
<ul style="list-style-type: none"> HIT and HIE capacity varies by organization 	<ul style="list-style-type: none"> BHT ACH will continue E WA ACH conversation with providers and MCOs across multiple ACHs to drive to shared approach and investment, and will continue to work with HCA on statewide alignment
---	--

Monitoring and Continuous Improvement

ACH Response

The goal of BHT ACH's monitoring plan is to use timely data to support project implementation, peer learning, and continuous improvement. BHT ACH will work with its contracted data vendor, Providence Center for Outcomes Research & Education (CORE), to design and implement a monitoring system that will track operational, process, and outcome measures for each project and Collaborative (see below) and for the ACH overall. The system will be designed to complement existing data assets (such as the Healthier Washington Data Dashboards, any Fully Integrated Managed Care early warning system, and relevant regional reports) and will refresh anytime a particular data feed is updated. Design will take place alongside implementation plan development in late 2017 and early 2018, so that the system is ready as projects move into implementation. A visual overview of BHT ACH's planned approach to monitoring and continuous improvement is shown below.

Planned approach for monitoring and continuous improvement



Monitoring metrics will include ACH toolkit pay-for-reporting and pay-for-performance metrics, as well as regional accountability and quality improvement plan metrics that speak to the effectiveness of BHT ACH's strategies within and across project areas. For the implementation phase, many metrics will be process or operational in focus (e.g. establishment of cross-setting data sharing agreements among Collaborative partners.) Final metrics will be identified in the implementation plan.

For the Bi-Directional Integration Project, the BHT ACH will be tracking, at a minimum, information on the following accountability measures:

- Anti-depression medication management
- Child and Adolescents' Access to Primary Care Practitioners
- Comprehensive Diabetes Care: HbA1c Testing
- Comprehensive Diabetes Care: Medical attention for nephropathy
- Comprehensive Diabetes Care: Eye Exam (retinal) performed
- Medication Management for People with Asthma (5 – 64 Years)
- Mental Health Treatment Penetration (broad)
- Plan All-Cause Readmission Rate (30 Days)
- Substance Use Disorder Treatment Penetration
- Follow-up After Hospitalization for Mental Illness
- Follow-up After Discharge from ED for Mental Health
- Follow-up After Discharge from ED for Alcohol or Other Drug Dependence
- Inpatient Hospital Utilization
- Outpatient Emergency Department Visits per 1000 Member Months

Plan for monitoring project implementation progress, including addressing delays in implementation

As shown in the diagram, the system will incorporate process measures for project implementation. Those process measures will be associated with timeframes and benchmarks identified by the ACH and the Collaboratives to provide immediate feedback when delays occur. The BHT ACH will work with CORE to develop a community dashboard to monitor key metrics identified in the toolkit and our community priorities. This will be a multi-functional dashboard extending beyond the MTD to allow ongoing community tracking and prioritization. Responsibility for addressing delays in implementation will lie with the Collaboratives, BHT governance bodies, and select BHT staff positions as described under 'Plan for monitoring continuous improvement' below.

Plan for monitoring continuous improvement, supporting partnering providers and determining whether or not BHT is on track to meet expected outcomes

A monitoring and continuous improvement system is more than just data; it's about the people, processes, and tools used to turn that data into actionable information that supports shared learning and quality improvement. In addition to creating a system to access and analyze data from different sources, the BHT ACH will rely on the following groups and positions to interpret the data, identify performance shortcomings or risks, and develop solutions:

- **Community Health Transformation Collaboratives.** As described elsewhere, BHT is launching a Spokane County Collaborative and a Rural Collaborative to develop and implement specific regional plans for health system transformation in the four project areas BHT has selected. The collaboratives' role will extend to: advising on design of the self-monitoring system; regularly reviewing the data that system provides; collaborating with the ACH to make course corrections as needed; and participating in shared learning opportunities within and across Collaboratives and ACH regions.
- **Provider Champion Council (PCC).** This recently established Council will provide general clinical expertise and subject matter expertise in different MTD project areas. The Council will monitor trends in performance across the Collaboratives to assess whether the BHT ACH is on track to

achieve expected outcomes and will advise on the Collaboratives' proposed risk mitigation and continuous improvement strategies. The PCC will also monitor individual Collaborative partners and advise on technical assistance necessary.

- BHT's **Director of Clinical Integration**, a position currently in recruitment, will support the clinical strategies for Bi-Directional Integration, Opioids, Chronic Disease and Care Coordination. Additionally, will staff the Provider Champion Council and identify, communicate, and address challenges to clinical integration and other transformation strategies.
- Jenny Slagle, Associate Director of Health System Transformation will serve as the **Pathways HUB Director** overseeing all operations of the Hub including training, quality assurance and improvement and strategic direction. Jenny will staff the Pathways Community Council that will launch in 2018. This position will closely monitor the data available from the HUB platform and intervene when Pathways are slow to complete or have encountered roadblocks.
- In its role as monitoring system lead, **CORE** will coordinate with BHT staff and the entities above to provide timely information, data interpretation expertise, and both technical and strategic support for peer learning and continuous improvement.
- BHT Board will receive monthly dashboards on key milestones and plans to address any risks
- BHT ACH's Regional Integration Team will also track key milestones specifically tied to FIMC and MTD project alignment

Plan for addressing strategies that are not working or not achieving outcomes

In combination, the people and workgroups described above and timely data from the monitoring system will enable the BHT ACH to identify strategies that are not working and to think through solutions in time to achieve project outcomes. If necessary, potential adjustments to implementation timelines will be triaged through the monitoring system to assess their impact on downstream goals. If timelines still cannot be met, the BHT ACH will inform HCA about the reasons and its plan for adapting the timeline, and preventing/risk mitigation strategies will be shared to other programs where appropriate.

Project Metrics and Reporting Requirements

Attest that the ACH understands and accepts the responsibilities and requirements for reporting on all metrics for required and selected projects. These responsibilities and requirements consist of:

- *Reporting semi-annually on project implementation progress.*
- *Updating provider rosters involved in project activities.*

YES	NO
X	

Relationships with Other Initiatives

Attest that the ACH understands and accepts the responsibilities and requirements of identifying initiatives that partnering providers are participating in that are funded by the U.S. Department of Health and Human Services and other relevant delivery system reform initiatives, and ensuring these initiatives are not duplicative of DSRIP projects. These responsibilities and requirements consist of:

- *Securing descriptions from partnering providers in DY 2 of any initiatives that are funded by the*

U.S. Department of Health and Human Services and any other relevant delivery system reform initiatives currently in place.

- *Securing attestations from partnering providers in DY 2 that submitted DSRIP projects are not duplicative of other funded initiatives, and do not duplicate the deliverables required by the other initiatives.*
- *If the DSRIP project is built on one of these other initiatives, or represents an enhancement of such an initiative, explaining how the DSRIP project is not duplicative of activities already supported with other federal funds.*

YES	NO
X	

Project Sustainability

ACH Response

BHT's strategy for long-term project sustainability, and its impact on Washington's health system transformation beyond the Demonstration period:

The BHT ACH understands that the bi-directional care integration project, along with the other project plans and Domain I efforts, must move the BHT ACH region forward in terms of developing a long-term clinical infrastructure and community structure able to provide seamless access to clinical and community services, where and when clients need them. To achieve this, the BHT ACH has developed the "scale and sustain" target population model that will begin with the highest need patients and conditions, and then roll out bi-directional care to the broader Medicaid population over time. Doing so will not only give providers time to develop and refine evidence-based bi-directional care models, but also develop insights and evidence about how best to implement bi-directional models and what kinds of interventions and approaches are most successful.

We are developing our Community Health Transformation Collaboratives with a focus on moving the region to Value Based Purchasing and whole person care. VBP is the cornerstone of our sustainability plan, recognizing the need to transition how we pay for care and linking Social Determinant of Health services. We are working to align data, funds flow, and model development to maximize the opportunity to integrate selected projects into a value based model and weave together local resources and investment to reach this goal. For instance, it is expected that the Board's funds flow policy will include directed investments for startup costs, infrastructure and technical assistance emphasizing MTD funding for transition, not an ongoing payment stream.

The bi-directional integration project plays a key role in supporting the move to VBP. Increased focus and investment in prevention, and scaling more efficient and connected intervention strategies, will lead to a more responsive community health system, better set up to succeed in VPB.

Key to this project is the Pathways Hub Model, which is as an anchor strategy – along with integration of care - for all our MTD work. Pathways offers an opportunity to better leverage an outcomes payment model to sustain care coordination and community capacity for the target population beyond the MTD period, to disrupt the cycle of fragile funding many social determinant of health partners face as government and philanthropic partners rotate through grant periods. We expect that Pathways will be funded through Medicaid MCOs and other innovative partnerships with philanthropic organizations and city and county governments throughout the region.

-
- ¹ HCA Co-occurring disorder tables, see: see:
<https://wahca.app.box.com/s/mxpg8euzbjpdkmyuftzb4ri5v41ia8v9/folder/39866406519>
- ² HCA hospitalizations_ach_rhni_tables:
<https://wahca.app.box.com/s/mxpg8euzbjpdkmyuftzb4ri5v41ia8v9/folder/23928005433>
- ³ HCA RHNI “starter set” files, see:
<https://wahca.app.box.com/s/mxpg8euzbjpdkmyuftzb4ri5v41ia8v9/folder/23928005433>
- ⁴ Washington Prescription Drug Monitoring Program, see:
<https://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/HealthcareProfessionsandFacilities/PrescriptionMonitoringProgramPMP/CountyProfiles>
- ⁵ HCA ACH Toolkit Historical Data:
<https://wahca.app.box.com/s/mxpg8euzbjpdkmyuftzb4ri5v41ia8v9/folder/36950052036>
- ⁶ Healthier Washington Data Dashboard, CY 2016 data: <https://www.hca.wa.gov/about-hca/healthier-washington/data-dashboard>
- ⁷ HCA ACH Toolkit Historical Data:
<https://wahca.app.box.com/s/mxpg8euzbjpdkmyuftzb4ri5v41ia8v9/folder/36950052036>
- ⁸ HCA Co-occurring disorder tables, see: see:
<https://wahca.app.box.com/s/mxpg8euzbjpdkmyuftzb4ri5v41ia8v9/folder/39866406519>
- ⁹ RDA Measure Decomposition files released 10-27-17. See:
<https://wahca.app.box.com/s/mxpg8euzbjpdkmyuftzb4ri5v41ia8v9/folder/41072598437>
- ¹⁰ RDA Measure Decomposition files released 10-27-17. See:
<https://wahca.app.box.com/s/mxpg8euzbjpdkmyuftzb4ri5v41ia8v9/folder/41072598437>

SECTION II: PROJECT-LEVEL

Transformation Project Description

Menu of Transformation Projects	
Domain 2: Care Delivery Redesign	
X	2B: Community-Based Care Coordination

ACH Response

Project Description and Justification

BHT will implement the Community-Based Care Coordination project as an anchor strategy (along with bi-directional integration of care) to connect the portfolio of projects in the Medicaid Demonstration and to develop accountable linkages between clinically-based health care services with the community-based services that play an integral role in improving health outcomes.

Justification for selecting project and how it addresses regional priorities

Research indicates that 80% of an individual's health is determined by what happens outside of the doctor's office.¹ To effectively address poor health outcomes, it is critical to employ models of care that complement the clinical interventions with efforts to address what are referred to as social determinants of health. Examples of these include access to affordable housing, education, transportation, and involvement with the criminal justice system. In the BHT region, data indicate the need to deploy a strategy that better connects clinical care with community-based resources to support improvements in health.

Regional data indicate the presence of significant social determinants of health with a relationship to poor health outcomes. While the overall employment rate across the BHT region is slightly higher than the statewide average (5.7% compared with 5.0%), the northern counties have some of the highest unemployment rates in the state: Pend Oreille and Ferry are the top two counties at 9.5% or 10% unemployment and Stevens County is at 8.8%.² According to the 2015 Washington State Housing Needs Assessment, all BHT counties have low numbers of affordable housing units, with Spokane County the lowest at 12 affordable and available units per 100 households.³ Providers in the BHT region report that between 3% and 18% of their clients live in housing that is either not stable or is overcrowded and that between 5% and 15% have a history of incarceration.⁴

Regional health data also underscore the significant need for care coordination. ED utilization in the BHT region (55%) is slightly higher than the statewide average (54%)⁵. More than 44,000 BHT Medicaid members (almost 30%) have been diagnosed with a mental illness and approximately 20,000 (12%) have a substance abuse treatment need. About 36,000 (9%) have a mental health or substance abuse condition *and* 1 or more chronic diseases. These

figures represent a larger segment of the Medicaid population for BHT than the corresponding figures for Washington as a whole.⁶ For those who have received a behavioral health disorder diagnosis (either mental illness or substance use disorder) BHT is slightly below the state average for mental health treatment and substance abuse treatment penetration rates among Medicaid beneficiaries, indicating that, access to treatment and management of these disorders remain a challenge.

Outside of pregnancy and childbirth, ‘mental and behavioral disorders’ were the leading cause of hospitalization for BHT Medicaid beneficiaries in 2015, accounting for 17.5% of all non-birth-related hospitalizations. Substance use disorders accounted for 5.7% of such hospitalizations overall but 8% among non-disabled adults.⁷

The Pathways Community Hub model offers the BHT ACH the opportunity to better connect the community-based social determinant of health system with the clinical delivery system to support at risk individuals to address the range of clinical and social factors impacting their health.

How Project will support sustainable health system transformation for the target population

A significant portion of what determines and individual’s health happens outside of a clinical provider’s office. The Pathways Community Hub model will demonstrate the value of identifying and addressing risk factors at the individual level and comprehensively approach treatment of each risk factors. Additionally, the opportunity to organize community resources in a more systematic and measured way will demonstrate the value of investing in social determinants of health services.

How BHT will ensure project coordinates with and doesn’t duplicate existing efforts

Better Health Together is supporting the development of two Community Health Transformation Collaboratives:

- 1) Rural Collaborative (comprised of Ferry, Stevens, Pend Oreille, Lincoln, Adams counties), and
- 2) Spokane County Collaborative

The BHT ACH is taking a regional approach to project design and implementation that will provide local autonomy and regional accountability. The Collaboratives will be responsible for developing and implementing actionable MTD plans across BHT’s project portfolio, and ensuring that the projects coordinate with each other and do not duplicate existing efforts in the region. The Collaboratives will be comprised of key partners with the expertise and experience required to transform our Medicaid Delivery System including clinics, Federally Qualified Health Centers (FQHCs), Hospitals, Mental health and Substance Use providers, Tribal Health systems, EMS, Jails and County Commissioners. This representation will ensure efforts are coordinated across the region and resources are leveraged.

In the summer 2017, Better Health Together (BHT) surveyed organizations in the region to complete a Health Systems Inventory (HSI) and/or Care Coordination Inventory (CCI) to learn more about the organizations' clients (including Medicaid coverage and health status), and gather provider interest, capacity, priorities, and existing efforts relating to MTD project areas. BHT received HSI and CCI responses from 39 unique organizations throughout the region, including hospital networks, behavioral and physical health providers, Public Health, FQHCs, MCOs, and community-based organizations. The CCI inventory identifies and details existing care coordination efforts across 29 agencies throughout the region. The Rural and Spokane County Collaboratives will build on information gathered through these inventories to coordinate and leverage existing care coordination to ensure that the Pathways Community Hub Care Coordination project does not duplicate existing efforts in the region. BHT and the Collaboratives will also work specifically with the region's Health Homes to assure the Pathways Community Hub referral process further support identification of Health Homes eligible individuals and does not duplicate care coordination for this patient population. We expect the Pathways Community Hub to complement the Health Homes efforts with high needs patients.

In the last month, Spokane County was awarded a nearly \$1 million grant from the Department of Justice to utilize the Pathways Community Hub as the anchor strategy for a local initiative to reform the local criminal justice system. In partnership with BHT, the County criminal justice, we will launch the Pathways Community Hub. This funding came in addition to a \$1.75 million grant from the MacArthur Foundation in April 2016 to help reduce the jail population by 21% by 2019. Funds from the MacArthur Foundation grant is being used to implement a newly developed risk assessment tool in the county's Pre-Trial Services Department, as well as a new racial equity toolkit.

Anticipated Project Scope & Target Population

The BHT ACH will implement the Pathways Community Hub with an initial focus on two populations: High Risk Pregnant Moms and People transitioning out of jail. These two high risk populations will individually benefit from the intervention and we expect to demonstrate multi-sector savings. The BHT ACH may expand to other populations in MTD Year 4 or 5 based on community needs.

The Medicaid Project Toolkit suggests a number of potential target populations for the community based care coordination project: Medicaid beneficiaries (adults and children) with one or more chronic disease or condition (such as, arthritis, cancer, chronic respiratory disease [asthma], diabetes, heart disease, obesity and stroke), or mental illness/depressive disorders, or moderate to severe substance use disorder and at least one risk factor (e.g., unstable housing, food insecurity, high EMS utilization). Looking closely at regional data and through our HSI, two key populations emerged as most likely to benefit from increased community-based care coordination and will be the initial target populations for this project.

Target Population	Population Estimate
People transitioning out of jail with either a mental health or substance use disorder treatment need	7,913 ⁸ -11,210 ⁹
Pregnant women / Medicaid moms	4,160 ¹⁰

Involvement of Partnering Providers

To support the development of the MTD project plan, the BHT ACH built on the experiences of the Ferry County Jail Transitions Pilot funded by State Innovation Model (SIM) launched in early 2017. The pilot offered several opportunities to work with providers from the Criminal Justice, Hospital, Clinic, and Community Action CHW to develop a powerful model to support individuals exiting jail. The anticipated pilot outcomes are to reduce the recidivism rate and health care costs of the Ferry County Jail.

Additionally, the BHT ACH LOI process identified 22 provider organizations interested in pursuing the Pathways Community Hub Model. Twenty-nine providers indicated interest in serving as a partnering provider for the Community-Based Care Coordination project as part of the HSI and CCI, this includes physical and behavioral health providers, housing, food security, social services, law enforcement, justice system, public health and early learning providers.

To further support development, the BHT ACH convened and met one-on-one with health and social determinant providers throughout the region currently working on care coordination to assess interest and support for the Pathways Community Hub process. The Pathways Community Hub model continues to garner deep support from partner organizations.

The following providers and organizations have expressed interest in serving as a partnering provider for a Care Coordination Project, through our open Letter of Interest process:

Provider/Partnering Organization	LOI for Project Implementation	LOI for Project Partnership
Aging and Long-Term Care of Eastern Washington	X	X
Catholic Charities Spokane		X
CHAS Health	X	
Communities in Schools		X
Consistent Care Services, SPC, PS	X	
Community Health Plan of Washington		X
East Adams Rural Healthcare	X	
Ferry County Public Hospital District	X	X
Empire Health Foundation	X	
Frontier Behavioral Health	X	
Greater Spokane County Meals on Wheels		X
Inland Northwest Health Services	X	
Kalispel Tribe of Indians	X	
Lake Roosevelt Community Health Centers		X
Lincoln County Health Department	X	

Merit Disability		X
National Alliance on Mental Illness		X
NHHS/ Pend Oreille Health Coalition		X
Northeast Tri County Health District	X	X
Odessa Memorial Healthcare Center	X	
Operation Healthy Family	X	X
Othello Community Hospital	X	
Pend Oreille Health Coalition	X	
Pioneer Human Services	X	X
Planned Parenthood		X
Providence Health Care	X	X
Rural Resources Community Action	X	X
SNAP		X
Spokane Neighborhood Action Partners	X	
Spokane Regional Health District	X	X
Washington Dental Service Foundation	X	X
YMCA		X
YWCA	X	

Additionally, the following organizations submitted Care Coordination Inventories detailing their specific capacity, experience, and interest in the 20 standard “Pathways” used in the Pathways Hub Model for Care Coordination:

Aging and Long Term Care of Eastern Washington
 American Indian Community Center
 Catholic Charities
 Consistent Care Services
 Daybreak Youth Services
 East Adams Rural Healthcare
 Eastern Washington University Head Start
 Excelsior Youth Center
 Ferry County Public Hospital District No. 1
 Frontier Behavioral Health
 Lincoln Hospital and Clinics
 Newport Hospital and Health Services (NHHS)
 Operation Healthy Family
 Partners with Families and Children
 Passages Family Support
 Pioneer Human Services
 Providence Health System
 Rural Resources Community Action
 Spokane Neighborhood Action Partners (SNAP)
 Spokane Regional Health District
 Spokane Treatment & Recovery Services

Volunteers of America
Yakima Valley Farmworkers Clinic
YFA Connections
YMCA of the Inland Northwest
YWCA Spokane

Level of Impact

In selecting our initial target populations, people transitioning out of jail and high risk pregnant moms, we focused on populations who typically have poor health outcomes, are high utilizers of community services and generate high health care costs. This target population also provides an opportunity to create multi sector savings and to pilot a shared savings model.

How BHT will ensure that health equity is addressed in the project design

Health equity is built into many elements of our MTD strategy including the Pathways Community Hub model. The Pathways Community Hub provides an evidenced based model of care that focused on empowering individuals to develop a care plan that meets their needs, increases access to a network of culturally-informed care agencies and utilizes a data infrastructure tool that can be used to monitor care, provider quality, and resource gaps in the community.

Better Health Together is ensuring that health equity is embedded in the MTD project design at multiple levels:

- *A Pathways Community Advisory Council (PCAC)* will be formed in early 2018 to conduct a RFP for care coordination agencies and complete the environmental scan work. This Council will include an appointee from the Tribal Partner Leaders Council and the Community Voices Council, MCOs, Social Determinant of Health Providers and Health Care Providers
- *Community Health Transformation Collaboratives:* Utilizing a Rural and Spokane County Collaborative model, BHT is ensuring attention and focus on local health disparities in our region. In addition, we expect Collaboratives to include organizations that bring diverse racial and cultural perspectives to MTD planning.
- *Community Voices Council:* BHT is launching a Community Voices Council, made up of at least 50% Medicaid beneficiaries or low-income community members, to empower and bring consumer voices to inform project design and implementation. This council will be tasked with developing health equity metrics by which to hold the Collaboratives and projects accountable to defined health equity goals and standards.
- *Target populations:* BHT is focusing projects on target populations experiencing the greatest health disparities. We are applying an “equity lens” to all our work by disaggregating data by race/age/ethnicity/sex/zip code wherever possible, both to make informed decisions about target populations and to monitor impact of projects across diverse groups. BHT will supply Collaboratives with regional data to guide early assessments of partners, and will direct these teams to identify populations within

their county that face a high level of disparities and/or present as highly complex or high risk.

- *Lived experience:* With the Community-based Care Coordination project, BHT is advancing the Pathways model and use of Community Health Workers with lived experience of health inequities. CHWs are critical to developing trust and culturally-appropriate strategies to meet the needs of our target populations across the Demonstration project areas.
- *Equity Accelerator Payment:* We anticipate implementing this incentive to support providers who serve a greater proportion of high-risk clients. The metrics tied to these payments will be determined by the Waiver Finance Workgroup, vetted by Provider Champions Council and Community Voices Council, and approved by the board.

Project's lasting impacts and benefit to the region's overall Medicaid population

The value of implementing the Pathways Community Hub care coordination project provides a solid framework to better manage and organize the clinical and community-based services needed to improve outcomes for high risk Medicaid enrollees.

We see two key benefits as the lasting impact of this model:

- **Ability to coordinate the coordinators:** High-risk patients often have many “care coordinators” that are unconnected or unaligned on care plans across different needs.
- **Pay for outcomes:** We will focus on initial target populations to establish a strong foundation and proof of concept for the model in the region. By doing so, the project will offer a sustainable model that can be deployed to other Medicaid enrollees in region to better link the community-based resources that are needed to strengthen and bolster the improved and transformed clinical system. This will support the region's shift to value-based payment and provide a more sustainable model for care coordinating organizations than the traditional model of having to rely on grants.

Implementation Approach and Timing

See Supplemental Workbook

Partnering Providers

See Supplemental Workbook

ACH Response

How BHT has included partnering providers that collectively serve a significant portion of the Medicaid population

BHT received Health System Inventory responses from 23 organizations in the region, including major hospital networks, provider systems, and FQHCs. In addition, BHT received 29

responses to the Care Coordination Inventory from community-based organizations. BHT compared the HSI respondents with HCA's September 2017 Provider Report¹¹ and found that the inventory responses represent more than 80% of the highest (top 10) volume Medicaid billers in each major setting (primary care, mental health/substance use disorder, inpatient and ED.) For several settings in BHT's five rural counties, the HSI respondents represent *all* the Medicaid billers with claims or beneficiary counts of more than 10 in 2016. BHT staff are following up with non-represented providers that see a large number of Medicaid clients, particularly substance use disorder treatment providers.

Process for ensuring partnering providers commit to serving the Medicaid population.

In 2018, the BHT ACH will formalize partnering provider participation in the care coordination project and other MTD project areas through a Transformation Compact process to ensure commitment to serving the Medicaid population. Through the ACH Leadership Council, Health System and Care Inventories, BHT ACH has a track record for engaging high volume providers in the region serving a significant portion of the Medicaid population. The BHT ACH has confidence they will commit to participation in the Collaborative and will formalize this commitment through the Transformation Compact.

Process for engaging partnering providers that are critical to the project's success, and ensuring that a broad spectrum of care and related social services is represented

BHT has been actively engaged with current Community-Based Care Coordination services in the region. The BHT Care Coordination Inventory (CCI) identified and detailed existing care coordination efforts across 29 agencies throughout the region. The Collaboratives will build on information gathered through this inventory to identify and engage partners critical to the project's success. BHT has also identified that representation from the following sectors is required for Collaboratives to successfully implement all projects. Each of these partners represent a critical setting for project implementation:

- Physical Health Clinical Providers
- Hospital System (including Emergency Department)
- Behavioral Health Clinical Providers
- Tribal Health Systems
- SUD Provider(s)
- Community-Based Chronic Disease Prevention and Mitigation
- Emergency Medical Services (first responders)
- Criminal Justice
- Community Based Care Coordinating Agency
- MCOs
- Crisis Management Services
- Liaison: Community Member/Consumer

Collaborative partnerships will be expanded as needed. In its role as the Pathways Hub, the ACH will serve as a connector between Collaborative providers and social and community partners. BHT ACH is also launching a Provider Champions Council to lend a practicing provider perspective to our work and to inform and validate Transformation Plans laid out by

Collaboratives.

How BHT is leveraging MCO's expertise in project implementation, and ensuring there is no duplication

Managed Care Organizations are actively involved in BHT's governance and leadership groups:

- Two MCO representatives, from Molina Health Care of Washington and Coordinated Care of Washington, are on the Board
- All five MCOs are voting members of BHT's Leadership Council and MCO staff participate in meetings and one-on-one sessions with the BHT team
- MCO representatives are on the BHT ACH Regional Integration Planning Team, Waiver Finance Workgroup, Provider Champions Council and Community Voices Council

MCOs will continue to participate in MTD project planning via these Technical Councils and through targeted collaboration with BHT ACH's Community Health Transformation Collaboratives.

In addition, BHT, Pierce County ACH, and Southwest ACH have collaborated on meetings with MCO partners to learn about key crossover areas between ACHs and MCOs under MTD, to ensure that the BHT ACH project strategy, support for providers/Domain 1 strategies, and monitoring and quality improvement efforts align with existing MCO activities and goals. Our discussions covered:

- Members/population overview
- PCP assignment/empanelment
- Provider support, particularly for value-based payment and related delivery system reform
- Measurement and quality improvement
- Member engagement/education
- Pathways Community Hub

In the BHT ACH discussions with MCOs, it was emphasized the importance of considering the needs and utilization patterns of different Medicaid populations (e.g. expansion adults vs. traditional Medicaid) and designing strategies that can integrate additional groups (e.g. dual special needs clients) over time to fully engage MCOs and other partners and support sustainability.

Additionally, the MCOs provided useful input about project feasibility and alignment with existing care coordination efforts. BHT will work with the MCOs to engage in planning ensure alignment and shared investment in preparing the region for both fully integrated managed care and value based purchasing. MCOs have been active participants in the formation of the Ferry County Pathways Pilot through our community design session and we will continue to engage MCOS in planning to ensure alignment and shared investment. To date, we have completed security assessments to contract with MCOs in Ferry County with United and Molina and are moving into a contracting process in December. We are in process with CHPW to contract for security assessments. Coordinated Care has expressed support for the

Pathways Community Hub model.

Regional Assets, Anticipated Challenges and Proposed Solutions

ACH Response

Assets the ACH and regional partners providers will bring to the project

Inventories: BHT has completed an extensive inventory process throughout the last two years of planning in order to “map” existing projects, pilots, and assets throughout the region. This has given us a comprehensive “current state” landscape assessment from which to base our initial project selection. These efforts include our Community Linkage Map, Community Strategy Maps, Health Systems Inventory, and Care Coordination Inventory.

Community Linkage Map: In 2016, the Spokane Regional Health District conducted a large-scale Community Linkage Mapping and social network analysis,¹² in which 165 individuals representing 112 organizations from the health, social service, education, business, and public sectors completed a Population and Social Determinants of Health Systems Survey. Because participants were able to describe their linkages with organizations that did not respond directly, the report in fact represents 564 organizations in the BHT region. A full list of participating organizations by geography and sector, which is the most comprehensive picture of health-relevant community-based resources in the BHT region, can be found as an Appendix to the RHNI section of this submission.

In 2013, BHT developed the **Navigator Network**, a successful initiative to provide In-Person Assistants to enroll people in Apple Health (Medicaid) and Qualified Health Plans on the Washington Health Benefit Exchange. Through these efforts, BHT successfully enrolled over 125,000 people in health insurance, many of whom have behavioral health diagnoses, and developed a robust network of partners throughout the region. As the operator of the Navigator Network of Eastern Washington, BHT has direct connections with more than 50 organizations who host or employ navigators. This provides credibility and important local connections to providers needed to successfully implement our MTD projects.

Recently Spokane County was awarded a Department of Justice Smart Reentry Grant for matching funds up to \$ 1 million dollars. This grant will support the Spokane County Jail Transition Pathways Pilot, including funding for care coordinating agency personnel, training, technology and organization infrastructure needs of the County and Pathways Community Hub. Anticipated outcomes are to increase communication, coordination, and collaboration for reentry population, increase use of evidence-based practices, and improve access to resources in the community for reentry support. This pilot will support the Spokane County Collaborative and allow a leverage of MTD resources.

Recognizing the need to support mutual regional strategic goals and make measurable improvements in health of rural communities, the Empire Health Foundation invested \$25,000 in Rural Resources Community Action to be a care coordinating agency for the Ferry County Pathways Pilot. This allowed the pilot to begin as small and manageable, allowing for growth as results and successful outcomes were obtained.

BHT is exploring a partnership with the City of Spokane to invest in the Housing Pathways Outcome payment. This would offer an opportunity for local jurisdictions to leverage other

resources to meet shared goals and reduce the financial pressure on MCOs to pay for every pathway. Please note that lack of housing in the BHT ACH region is the biggest social determinants of health barrier.

BHT is also exploring a partnership with the ARCORA Foundation to ensure oral health access and services are available for at-risk patients. In 2017, the Washington State Legislature mandated the Health Care Authority and ARCORA Foundation to work together to develop a pilot, Oral Health Connections, in three communities (including Spokane, County) with two target populations – patients with diabetes and pregnant women. Dentists serving these populations will receive enhanced reimbursements for doing so.

Challenges to improving outcomes and lowering costs for target population and strategy to mitigate risks and overcome barriers

BHT has identified several key challenges to successful implementation of the Pathways Community Hub model. These include:

- *HIT/HIE capacity:* Based on provider HSI responses, HIT and HIE capacity seems to vary strongly among different organizations. With a few exceptions, capacity around information exchange is limited (e.g. system can send summaries out but not accept data in, or there is a data sharing relationship with specific partners only, like an FQHC and the BHO). While the Pathways Community Hub platform offers a flexible technology the ability to connect with existing systems will need to be explored.
- *Workforce needs:* Based on provider HSI responses, workforce needs are a significant concern. Recruiting, training and providing Community Health Workers with a living wage may be a significant challenge for the region.
- *Resources:* Limitations in regional/local behavioral health providers and social determinant of health resources may directly impact successful completion of Pathways.

Strategies for overcoming barriers

- *HIT/HIE capacity:* we will work with organizations to better link community based care coordination efforts using the Care Coordination Systems platform by building application program interfaces between CCS and organizations health record management systems. This will allow all Pathways Community Hub partners real-time information to serve their clients in a more effective manner. Many BHT ACH partners have cited the CCS platform flexibility and interoperability potential as a major reason for future adoption.
- *Workforce needs:* many, if not all, potential care coordinating agencies in the BHT ACH region already employ care coordinators, ranging from community based organizations, health clinics, hospitals, and behavioral health providers. As part of the MTD Care Coordination project plan we will support transitioning current care coordinators to the Pathways Community Hub model. In early 2017, sixteen participants were trained in the Pathways Community Hub model and CCS platform.

Organizations ranged from rural and urban CHWS, Community Organizations, Health Homes, and MCO staff. The Spokane Regional Health District conducts all regional CHW training on behalf of the WA State Department of Health and facilitates the Eastern Washington Community Health Worker Network. The BHT ACH is an active participant and member of the leadership team of this local coalition of CHWs that meet monthly for information sharing and capacity building. In October 2017, the BHT Director of Community Engagement presented on the ongoing ACH work to over 40 CHWs to further improve CHW workforce buy-in and feedback. The Pathways Community Hub care coordinators will be required to complete the CHW training offered via the Washington State Department of Health and participate in local and regional learning opportunities that support the development of a robust care coordination community. The BHT ACH Pathways Hub will provide training on the Pathways Hub model, CCS technology platform and coordinate information and education opportunities through webinars, calls, newsletters, etc. BHT ACH will host regular in-person learning events that address common challenges of care coordinators and agencies.

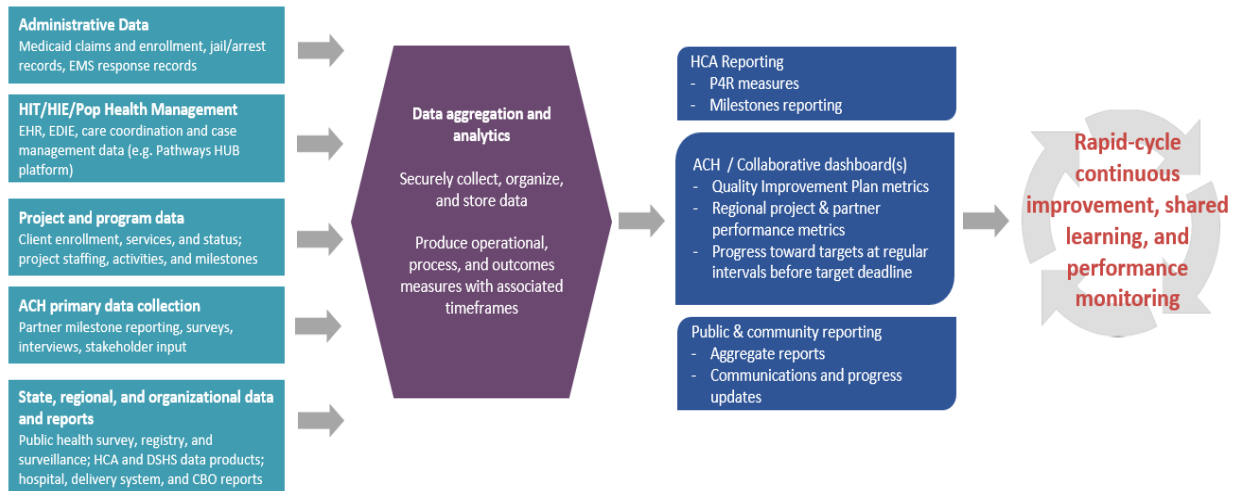
- Resources: The BHT ACH will foster connections between regional partners to ensure investment resources and infrastructure to close gaps in our region. Through the reporting capability of the CCS platform, we'll be able to quantify gaps in resource availability and advocate for more local and state investment. Additionally, the BHT ACH staff work closely with the local Washington Information Network 211 to ensure that community resource databases are up-to-date and ready for larger scale use by care coordinators.

Monitoring and Continuous Improvement

ACH Response

The goal of BHT's monitoring plan is to use timely data to support project implementation, peer learning, and continuous improvement. BHT will work with its contracted data vendor, Providence Center for Outcomes Research & Education (CORE), to design and implement a monitoring system that will track operational, process, and outcome measures for each project and Collaborative (see below) and for the ACH overall. The system will be designed to complement existing data assets (such as the Healthier Washington Data Dashboards and—particularly for Community Care Coordination, the HUB data platform) and will refresh anytime a particular data feed is updated. For the implementation phase, many metrics will be process or operational in focus (e.g. developing guidelines, policies and protocols to implement the Pathways). Final metrics will be identified in the implementation plan. Design will take place alongside implementation plan development in late 2017 and early 2018, so that the system is ready as projects move into implementation. A visual overview of BHT's planned approach to monitoring and continuous improvement is shown below.

Planned approach for monitoring and continuous improvement



Plan for monitoring project implementation progress, including addressing delays in implementation

As shown in the diagram, the system will incorporate process measures for project implementation. Those process measures will be associated with timeframes and benchmarks identified by the BHT ACH and its Collaboratives to provide immediate feedback when delays occur (for example, any potential challenges in hiring staff to operate the Pathways Community Hub). We plan to work with CORE to develop a community dashboard to monitor key metrics identified in the waiver and our community priorities. This will be a multi-functional dashboard extending beyond the waiver to allow ongoing community tracking and prioritization. Responsibility for addressing delays in implementation will lie with the Collaboratives, BHT governance bodies, and select BHT staff positions as described under ‘Plan for monitoring continuous improvement’ below.

Plan for monitoring continuous improvement, supporting partnering providers and determining whether or not BHT is on track to meet expected outcomes

A monitoring and continuous improvement system is more than just data; it’s about the people, processes, and tools used to turn that data into actionable information that supports shared learning and quality improvement. In addition to creating a system to access and analyze data from different sources, the BHT ACH will rely on the following groups and positions to interpret the data, identify performance shortcomings or risks, and develop solutions:

- **Community Health Transformation Collaboratives.** As described elsewhere, BHT is launching a Rural and Spokane County Collaboratives to develop and implement specific regional plans for health system transformation in the four project areas BHT has selected. The Collaboratives’ role will extend to: advising on design of the self-monitoring

system; regularly reviewing the data that system provides; collaborating with the ACH to make course corrections as needed; and participating in shared learning opportunities within and across Collaboratives and ACH regions.

- **BHT Provider Champions Council.** This recently established Council will provide general clinical expertise and subject matter expertise in different MTD project areas. The Council will monitor trends in performance across the Collaboratives to assess whether BHT is on track to achieve expected outcomes and will advise on the Collaboratives' proposed risk mitigation and continuous improvement strategies. The PCC will also monitor individual collaborative partners and advise on technical assistance necessary.
- Jenny Slagle, Associate Director for Health System Transformation will serve as the **Pathways Community Hub Director** overseeing all operations of the hub including training, quality assurance and improvement and strategic direction. Jenny will staff the Pathways Community Advisory Council that will launch in 2018. This position will closely monitor the data available from the HUB platform and intervene when Pathways are slow to complete or have encountered roadblocks.
- BHT's **Director of Clinical Integration**, a position currently in recruitment, will staff the Provider Champion Council and help identify, communicate, and address challenges to clinical integration and other transformation strategies.
- In its role as monitoring system lead, **CORE** will coordinate with BHT staff and the entities above to provide timely information, data interpretation expertise, and both technical and strategic support for peer learning and continuous improvement.
- BHT's board will receive monthly dashboards on key milestones and plans to address any risks
- BHT's Regional Integration team will also track key milestones specifically tied to FIMC and MTD project alignment

Plan for addressing strategies that are not working or not achieving outcomes

In combination, the people and workgroups described above and timely data from the monitoring system will enable the BHT ACH and its partnering providers to identify strategies that are not working and to think through solutions in time to achieve project outcomes. If necessary, potential adjustments to implementation timelines will be triaged through the monitoring system to assess their impact on downstream goals. If timelines still cannot be met, BHT will inform the state about the reasons and its plan for adapting the timeline, and preventing/risk mitigation strategies will be shared to other programs where appropriate.

BHT will continue to receive technical assistance from Dr. Sarah Redding with the Pathways Community Hub Certification Program, and Care Coordination Systems project management team on the implementation of the Pathways Community Hub in our region.

Project Metrics and Reporting Requirements

Attest that the ACH understands and accepts the responsibilities and requirements for reporting on all metrics for required and selected projects. These responsibilities and requirements consist of:

- *Reporting semi-annually on project implementation progress.*
- *Updating provider rosters involved in project activities.*

YES	NO
X	

Relationships with Other Initiatives

Attest that the ACH understands and accepts the responsibilities and requirements of identifying initiatives that partnering providers are participating in that are funded by the U.S. Department of Health and Human Services and other relevant delivery system reform initiatives, and ensuring these initiatives are not duplicative of DSRIP projects. These responsibilities and requirements consist of:

- *Securing descriptions from partnering providers in DY 2 of any initiatives that are funded by the U.S. Department of Health and Human Services and any other relevant delivery system reform initiatives currently in place.*
- *Securing attestations from partnering providers in DY 2 that submitted DSRIP projects are not duplicative of other funded initiatives, and do not duplicate the deliverables required by the other initiatives.*
- *If the DSRIP project is built on one of these other initiatives, or represents an enhancement of such an initiative, explaining how the DSRIP project is not duplicative of activities already supported with other federal funds.*

YES	NO
X	

Project Sustainability

ACH Response

BHT strategy for long-term project sustainability

Better Health Together is developing our Community Health Transformation Collaboratives with a focus on moving the region to value based purchasing and whole person care. VBP is the cornerstone of our sustainability plan recognizing the need to transition how we pay for care and linking social determinant of health services to health care services. We are working to align data, funds flow, and model development to maximize the opportunity to integrate selected projects into a value based model and weave together local resources and investment to reach this goal. For instance, it is expected that the BHT Board's funds flow policy will include directed investments for startup costs, infrastructure and technical assistance emphasizing DSRIP funding for transition, not an ongoing payment stream.

Community Health Transformation Collaboratives are designed to support the early formation of the natural partnerships needed to support a geographically based health system's success in a value based system. The linkages created to support these projects will translate to the relationships need to succeed in a value-based model and improve population health. These partnerships will sustain themselves as shared savings are re-invested in Collaborative efforts. The support from the ACH, MTD funds, and Collaborative partners, will create an environment to test new processes and implement new projects.

The Pathways Community Hub will develop contracts with MCOS and other funders for outcome based payments tied to successful completion of Pathways. This offers a sustainable funding model for care coordination and shared savings.

Finally, the Community Resiliency fund is an area of the MTD projects we expect to be sustained past the MTD period. BHT will develop a community dashboard that monitors key social determinant and health indicators of our regional health system's viability. By aligning regional partners and investors around these indicators, using demonstration as an incubator, we can create an investment fund of flexible dollars for the region to continue to use for strategic investment in overcoming health disparities.

Project's impact on Washington's health system transformation beyond the Demonstration period

The Pathways Community Hub model is central to our MTD efforts and the region's efforts to move to Value Based care. The Pathways Community Hub model offers a scalable opportunity to link care coordination and to improve health outcomes through a sustainable model of care beyond typical philanthropic/government contracts. By implementing the Pathways Community Hub, we will demonstrate the value of better linking efforts to address social determinants with clinical efforts to improve health outcomes. Other states have implemented the Pathways Community Hub and found success in developing long term contracts with funders (not limited to MCOs). This will result in improved community capacity to link health social determinant of health support with at risk patients that will last beyond the MTD period.

¹ WHO (World Health Organization). 2012. What are the social determinants of health? http://www.who.int/social_determinants/sdh_definition/en/

² Based on 2015 data, RWJF County Health Rankings: <http://www.countyhealthrankings.org/>

³ See: <http://www.commerce.wa.gov/housing-needs-assessment>. Affordable (meaning they cost less than 30% of average household income) & available units per 100 households in BHT counties are: Adams 22, Ferry 26, Lincoln 22, Pend Oreille 26, Spokane Co. 12, Stevens 26. Spokane metro area has 14 affordable & available housing units per 100 households.

⁴ BHT Health Systems Inventory (2017).

⁵ HCA ACH Toolkit Historical Data:

<https://wahca.app.box.com/s/mxpg8euzbjpdmyuftzb4ri5v41ia8v9/folder/36950052036>

⁶ HCA Co-occurring disorder tables, see:

<https://wahca.app.box.com/s/mxpg8euzbjpdmyuftzb4ri5v41ia8v9/folder/39866406519>

⁷ HCA hospitalizations_ach_rhni_tables: <https://wahca.app.box.com/s/mxpg8euzbjpdkmyuftzb4ri5v41ia8v9/folder/23928005433>. (Note that 1/3 of Medicaid-paid hospitalizations in BHT's region that were not related to pregnancy/childbirth were classified as stemming from "other causes" in the available data)

⁸ This is an upper-bound estimate based on finding from 2013 analysis estimating that 60% of WA jail inmates *who were enrolled in Medicaid in 2012 or 2013* had a mental health need and assuming that the same proportion applies to inmates without a recent history of Medicaid enrollment. See:

<http://sac.ofm.wa.gov/sites/all/themes/wasac/assets/docs/research-11-226a.pdf>

⁹ This is an upper-bound estimate based on uncited figure from Spokane County Corrections that 85% of inmates have a behavioral health need.

¹⁰ Washington DOH Vital Statistics Medicaid-paid births, 2015 data. See:

<https://www.doh.wa.gov/DataandStatisticalReports/HealthStatistics/Birth/BirthTablesbyYear>

¹¹ HCA ACH Toolkit Provider Report Files updated 09.01.17, see:

<https://wahca.app.box.com/s/mxpg8euzbjpdkmyuftzb4ri5v41ia8v9/folder/30748038709>.

¹² Spokane Regional Health District Data Center (2017). Community Linkage Mapping: General Report. An assessment of the regional population and social determinants of health systems. <https://goo.gl/1WDBpo>. See also the interactive map available at: <http://arcg.is/2pH9kuT>

SECTION II: PROJECT-LEVEL

Transformation Project Description

Menu of Transformation Projects

Domain 3: Prevention and Health Promotion

X	3A: Addressing the Opioid Use Public Health Crisis (required)
---	---

ACH Response

The Opioids Project will support Washington State's goals of reducing opioid-related morbidity and mortality. Better Health Together Accountable Community of Health (BHT ACH) will align community efforts to promote prevention, access to treatment, overdose prevention, and recovery for area residents, focusing specifically on adults and youth enrolled in Medicaid via our Rural and Spokane County Collaboratives.

Justification for selecting project and how it addresses regional priorities

The opioid crisis has skyrocketed in Washington and the BHT ACH region, and it is affecting the Medicaid population. According to the University of Washington Alcohol and Drug Abuse Institute, three counties in the BHT ACH (Ferry, Lincoln and Pend Oreille) each had a rate of publicly funded admissions for opioids of between 90 and 180 per 1,000 residents between 2011 and 2013. Spokane and Stevens Counties each had 180-360 admissions per 1,000 residents in this same period.¹ Opioid related treatment and deaths increased across the state over the past decade, mirroring a growing problem nationally.

Across the BHT ACH region, 17.4 percent of Medicaid enrollees are opioid users. This rate is high compared to the overall Washington rate of 13.5 percent of all Medicaid enrollees, and all counties in the region except Adams have a higher rate of opioid use than the state as a whole. While not all opioid users are dependent, over 7,000 people (3.6 percent of Medicaid enrollees) meet the CDC definition of heavy opioid users, and 3.9 percent of the population has used opioids for over 30 days. Over six thousand people (3.2 percent of Medicaid enrollees in the region) are opioid dependent or abusing, based on ICD9 and ICD10 codes over a two-year claims period.²

Table 1: Opioid use among Medicaid beneficiaries, BHT and WA state

Medicaid Opioid Use Data	BHT	Washington
Opioid Users as % of Medicaid population		
All	17.4%	13.5%
Users without cancer	15.4%	11.9%
Heavy Users	3.6%	2.8%
Users for > 30 days	3.9%	2.8%
Diagnosis history of opioid abuse or dependence		

All	3.2%	2.7%
Males	3.2%	2.8%
Females	3.2%	2.6%

Better Health Together has higher rates of opioid overdose events than the state average and, in 2016, had the highest rates among *all* ACHs for opioid overdose-related hospitalizations and ED visits. The data in the table below come from the Washington Department of Health's Opioid Overdose Dashboard.

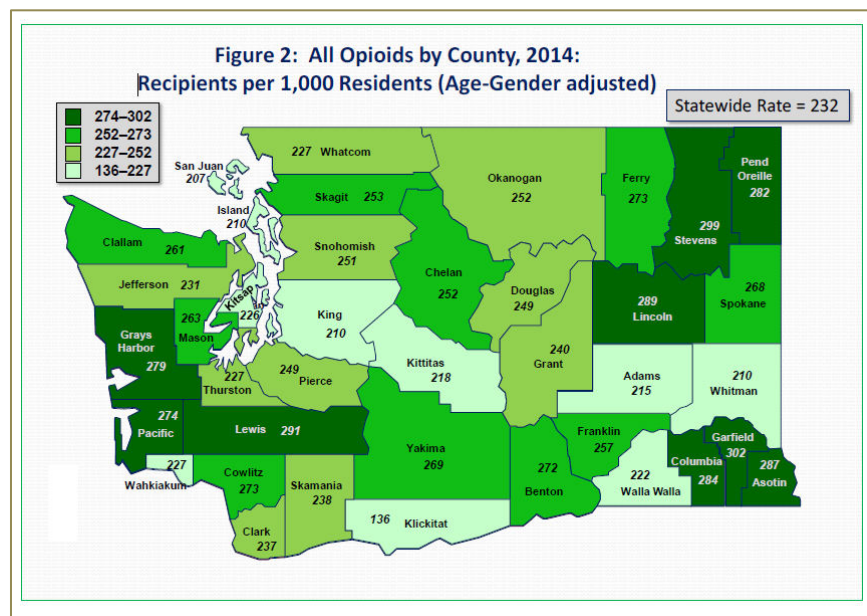
Revised³ Table 2: Opioid-related events, BHT region and WA state⁴

Opioid-related events, 2016	BHT	Washington
<i>All numbers are general population rates per 100,000</i>		
Opioid overdose deaths	11.1	10.1
Opioid overdose hospitalizations	27.6	20.2
Opioid overdose ED visits	94.1	45.1

Note: Hospitalizations are based on patient's county of residence, whereas deaths and ED visits are based on county of occurrence and facility location, respectively.

Data suppression makes it difficult to estimate the number of active opioid prescribers for the Medicaid population in BHT's region. However, information from the Prescription Drug Monitoring Program suggests that opioid prescriptions are written and filled at elevated rates in most of BHT's counties, as compared to the state.

Figure 1: Opioid prescriptions written and filled per 1,000 residents, 2014⁵



The region has hosted several discussions and efforts over the last few years, though none of these efforts have sustained nor created significant change. The BHT ACH will align toolkit

requirements into our clinical setting efforts via our Collaboratives to implement best practices and evidence-based strategies. Additionally, via our ACH Leadership Council, Provider Champions Council, Community Voice Council and Tribal Partner Leaders Council efforts, we will align other community efforts related to opioid prevention, such as ARCORA's effort to support an oral health local impact network with a focus on reducing opioid use disorder. This strategy will assist us in building a robust network of dental practices who are a key source of opioid prescribing, and involvement and leadership from the dental community which will be a key success factor for establishing a more coordinated response to opioid-addiction prevention and treatment activities.

How Project will support sustainable health system transformation for the target population

This project will support sustainable health system transformation for the target population by fostering cross-sector partnerships that leverage our local resources to reverse the opioid epidemic in our region. The project will foster delivery system changes that support coordination and collaboration across providers, promote appropriate prescribing, patient-centered treatment and recovery-oriented care, and Value Based Payment (VBP) models that incentivize and sustain these system changes.

How Better Health Together will ensure project coordinates with and doesn't duplicate existing efforts

Better Health Together is supporting the development of two Community Health Transformation Collaboratives:

1. Rural Collaborative (comprised of Ferry, Stevens, Pend Oreille, Lincoln, and Adams Counties)
2. Spokane County Collaborative

The BHT ACH is taking a regional approach to project design and implementation that will provide local autonomy and regional accountability. The Collaboratives will be responsible for developing and implementing actionable MTD plans across BHT's project portfolio, and ensuring that the projects coordinate with each other and do not duplicate existing efforts in the region. The Collaboratives will be comprised of key partners with the expertise and experience required to transform our Medicaid Delivery System including clinics, Federally Qualified Health Centers (FQHCs), Hospitals, Mental health and Substance Use providers, Public Health, Tribal Health systems, EMS, Jails and County Commissioners. This representation will ensure efforts are coordinated across the region and resources are leveraged.

In the Summer 2017, BHT ACH also surveyed organizations in the region to complete a Health Systems Inventory (HSI) or Care Coordination Inventory (CCI) to gather provider interest, capacity, priorities and information about existing work in the region relating to the MTD project areas. Based on provider HSI responses, a key area where we see the opportunity for coordination is in the use of The Six Building Blocks for Pain Management and Safe Opioid

Therapy. The Six Building Blocks (6-BBs) model provides a roadmap that facilitates engagement of primary care teams in providing safer, more effective care to patients with chronic pain who use opioids daily. The 6-BBs include:

1. Engaging leadership and securing consensus
2. Revising policies and standard work
3. Tracking patients on chronic opioid therapy
4. Planning for visits and providing patient-centered care
5. Developing resources to care for complex patients (e.g., addiction)
6. Measuring success

BHT ACH is working with at least two rural providers engaged with this effort, and further exploring the extent to which other providers in the region are also participating. The HSI indicates that few partners do not or are not able to offer Medication Assisted Therapy because of lack of providers or resources.

Anticipated Project Scope

BHT ACH proposes to address opioids in the region through four interconnected initiatives focused on providers and Medicaid consumers. These efforts align with the Washington State Opioid Response Plan.

Initiative 1: Prevention – Improve Provider Prescribing Practices

- **Strategy 1: Via our Transformation Collaboratives**, provide additional support to providers regarding prescribing practices, accessing patient information and history, and increasing non-opioid pain management strategies.
 - As part of the Collaborative assessment, identify provider understanding of prescribing guidelines and target training and coaching to providers with most need
 - As part of the Collaborative technical assistance plan, promote best practices for prescribing opioids for acute and chronic pain, including increasing the use of the Prescription Drug Monitoring Program (PDMP) by more providers.
 - Distribute Washington State Medical Association/Washington State Hospital Association/Health Care Authority opioid prescribing variance reports that include feedback and comparison metrics, so that prescribers can evaluate their prescribing practices relative to others in the state.
 - Provide training and information on Washington State Agency Medicaid Director's (AMDG) prescribing guidelines. Promote adoption of the Six Building Blocks for opioid pain management by primary care providers and promote access to the team of Six Building Blocks experts and practice coaches for individual consultation and assistance with implementation with primary care practices.
 - Increase leadership and consensus around safe prescribing.
 - Use a registry to proactively manage patients.
 - Revise policies and standard work to support safe prescribing.

- Increase patient-centered care.
 - Provide care for complex patients
 - Measure success
- It is expected that Collaboratives will measure increased physicians' use of the Prescription Drug Monitoring Program (PDMP):
 - Facilitate integration of the PDMP with electronic health records systems.
 - Offset administrative costs associated with manually checking the PDMP (for providers unable to integrate).
- Increase the use of telehealth to improve capacity in rural areas.
- Promote the use of non-opioid pain management and reduce the risk of chronic use through improved prescribing practices. According to a recent study published by the CDC, the likelihood of chronic opioid use increased with each additional day of medication supplied starting with the third day, and with the sharpest increases after the fifth day on therapy and again after the 31st day⁶. Improved prescribing practices will help reduce the size of the target population by preventing the development of chronic use.
- **Strategy 2: Work with partners to increase understanding of adverse effects of opioid use**
 - As part of the Collaborative assessment process, each Collaborative group will assess the availability and quality of educational materials for consumers.
 - Promote accurate and consistent messaging about opioid safety and to address the stigma of addiction.
 - Utilize community care coordinators and other community members to conduct peer outreach and education.
 - Promote national social marketing campaigns on the potential harms of prescription medication misuse and abuse and secure home storage.
- **Anticipated Outcomes, the Medicaid Waiver Finance Group will explore tying incentive payments to these outcomes.**
 - Improve baseline understanding of provider knowledge and training needs
 - Increase provider, consumer and community level understanding of impacts of opioid use, alternatives to opioids for pain relief.
 - Increase number of prescribers aware of their prescribing patterns and trained on AMDG guidelines.
 - Increase number of prescribers registered for and using the PDMP.
 - Reduce high-dose prescription opioid therapy for chronic use.
 - Reduce number of concurrent sedative prescriptions.
 - Reduce opioid related inpatient stays and emergency department visits.

Initiative 2: Treatment – Support Providers, Increase Access to Services

- **Strategy 1:** Educate providers to identify potential opioid misuse, Opioid Use Disorder (OUD), and on the available treatment options.
 - As part of our Opioid strategy and our Pathways Community Hub regional

- assessment, identify existing community-level treatment resources
 - As part of our work through Regional Health Transformation Collaborative and technical assistance and training provision:
 - Educate providers on how to recognize signs of opioid misuse and OUD among patients and how to use appropriate tools to identify OUD.
 - Increase provider ability to have supportive patient conversations about problematic opioid use and treatment options.
 - Provide pharmacists with tools to promote referrals for opioid prescription misuse.
- **Strategy 2:** Increase access to and use of community-level OUD.
 - Increase the number of local providers certified to prescribe OUD medications.
 - Work with the Health Care Authority to identify policy changes that could improve availability and use of treatment options.
 - Utilize community resources (CHWs, Pathways Community hub partners, social service organizations and 211) to support peer learning and support for OUD treatment.
 - Support effort to increase access to buprenorphine.
 - Improve communication between physicians and psychosocial providers.
- **Strategy 3:** Target high-impact patients for specialized intervention and education (pregnant and parenting women)
 - As part of our Collaborative Technical Assistance
 - Increase providers' awareness and use of *Substance Abuse during Pregnancy: Guidelines for Screening and Management*, the Washington State Hospital Association Safe Deliveries Roadmap standards.
 - Educate pediatric and family medicine providers to recognize and appropriately manage newborns with NAS.
 - Work with MCOs and HCA to increase the number of obstetric and maternal health care providers permitted to dispense and prescribe MAT through the application and receipt of DEA approved waivers.
 - Work with clinical and social services providers to improve access to the range of services that address physical, mental and substance use disorder treatment needs during, through and after pregnancy.
- **Anticipated Outcomes: The Medicaid Waiver Finance Group will explore tying incentive payments to these outcomes.**
 - Increase access to treatment (including MAT) for Medicaid beneficiaries
 - Increase access to the full range of services to treat the whole person and support treatment success

Initiative 3: Overdose Prevention

- **Strategy 1:** Increase availability and use of naloxone.
 - Establish standing orders in all counties and all opioid treatment programs to authorize community-based naloxone distribution and lay administration.
 - Encourage providers to prescribe naloxone for pain patients.
- **Strategy 2:** Educate targeted consumers (opioids and heroin users and providers and

others who interact with users) about how to recognize and respond to an overdose.

- Educate first responders, chemical dependency counselors, and law enforcement on opioid overdose response training and naloxone programs.
- Help emergency providers develop and implement overdose education protocols, encourage them to send home naloxone with patients seen for opioid overdose.
- **Strategy 3:** Increase general understanding about Washington State's Good Samaritan Law.
 - Work with the Center for Opioid Safety Education to educate law enforcement, prosecutors and the public about the Good Samaritan Response Law.
- **Anticipated Outcomes:**
 - Increase access to naloxone for individuals using heroin and opioids, and for clinical and lay responders.
 - Reduce opioid overdose deaths.

Initiative 4: Recovery

- **Strategy 1:** Improve access to recovery supports and long-term stabilization.
 - Build on existing community efforts to support a regional approach to create a recovery culture including the scaling of the Recovery Care, Pathways Hub and care coordinators, along with CHWs to increase use of peer and other recovery support services designed to improve treatment access and retention and support long-term recovery.
 - Support access to harm-reduction techniques.
 - Connect SUD providers with physical and behavioral health providers social services organizations and peer supports to address access, referral and follow up for services.
- **Anticipated Outcomes: The Medicaid Waiver Finance Group will explore tying incentive payments to these outcomes.**
 - Increase number of Medicaid enrollees with OUD who access care coordination through the Pathways Hub. Increase referrals and follow up treatment, including to recovery supports and harm reduction services.

Anticipated Target Population

The target population is adult and youth Medicaid beneficiaries who use, misuse, or abuse prescription opioids or heroin. This target population will include approximately 7,688 individuals in the BHT ACH region who have used opioids for more than 30 days.⁷ As indicated in the strategies, providing special assistance to populations for whom opioid misuse has immediate and systemic impacts (e.g. pregnant women) will be a priority. Among Medicaid beneficiaries in the region and state, women are somewhat more likely to be heavy opioid users than are men (in the BHT ACH catchment area, women make up 58 percent of heavy opioid users despite being only 51 percent of overall enrollment)⁵

Involvement of Partnering Providers

To develop the proposed project, BHT ACH has convened and met one-on-one with partnering providers throughout the region working on opioid-related efforts. In addition, BHT ACH engaged providers in an LOI process to identify provider interest in MTD project areas. These efforts have directly informed the development of the proposed Opioid project priorities and BHT's proposal to develop regional Collaboratives to further develop MTD projects in 2018. The following providers and organizations have expressed interest in serving as a partnering provider for project implementation and/or partnership for Opioid Response:

Provider/Partnering Organization	LOI for Project Implementation	LOI for Project Partnership
Aging and Long-Term Care of Eastern Washington	X	X
Catholic Charities Spokane		X
CHAS Health	X	
Communities in Schools		X
Consistent Care Services, SPC, PS	X	
Community Health Plan of Washington		X
East Adams Rural Healthcare	X	
Ferry County Public Hospital District	X	X
Empire Health Foundation	X	
Frontier Behavioral Health	X	
Greater Spokane County Meals on Wheels		X
Inland Northwest Health Services	X	
Kalispel Tribe of Indians	X	
Lake Roosevelt Community Health Centers		X
Lincoln County Health Department	X	
Merit Disability		X
National Alliance on Mental Illness		X
NHHS/ Pend Oreille Health Coalition		X
Northeast Tri County Health District	X	X
Odessa Memorial Healthcare Center	X	
Operation Healthy Family	X	X
Oral Healthcare LLC	X	
Othello Community Hospital	X	
Pend Oreille Health Coalition	X	
Pioneer Human Services	X	X
Planned Parenthood		X
Providence Health Care	X	X
Rural Resources Community Action	X	X
SNAP		X
Spokane Neighborhood Action Partners	X	
Spokane Regional Health District	X	X

Virginia Matheny	X	
Washington Dental Service Foundation	X	X
YMCA		X
YWCA	X	

Additionally, seventeen (17) of the organizations who completed a Health Systems Inventory expressed explicit interest in serving as a partnering provider on an Opioid Response project. The following providers are either currently implementing evidence-based programs to address Opioids within their settings, or have expressed interest in adopting models as a partner in an Opioid MTD project:

- Columbia Basin Hospital Association
- CHAS Health
- East Adams Rural Healthcare
- Excelsior Youth Center
- Ferry County Public Hospital District
- Lincoln Hospital
- The NATIVE Project
- NE Tri County Health District
- Newport Hospital
- Odessa Memorial Hospital
- Planned Parenthood
- Providence Health Services
- Rockwood Clinics
- Spokane Regional Health District
- Spokane Treatment Addiction and Response Services
- YFA Connections
- Unify Community Health

These providers and organizations involved serve the majority of Medicaid beneficiaries in the region and are critical to the success of this effort. In addition to our partnering providers, BHT will collaborate closely with the ARCORA Oral Health Spokane Local Impact Network Opioid Task Force – a BHT Board member, Torney Smith, chairs this task force.

Level of Impact

Better Health Together is identifying target populations based on examination of regional data demonstrating key health disparities. As noted above, providing special assistance to populations for whom opioid misuse has immediate and systemic impacts (e.g. pregnant women) will be a priority.

While opioid use and use disorder is an issue across the region, some areas appear to be more impacted than others. For example, Prescription Drug Monitoring Program data show elevated rates of opioid prescribing in Lincoln, Pend Oreille, and Stevens Counties⁸ (see map earlier in this section) and Pend Oreille County had the second highest rate of opioid overdose fatalities in the state between 2011 and 2015,⁹ although small numbers make that rate subject to fluctuation. As we work to connect our opioid project work to larger systemic efforts to reduce Adverse Childhood Events (ACEs), it is clear that reducing opioid addiction and deaths benefits not only the individuals with OUD, but their families and communities.

This is particularly an issue for children of opioid users. Having one or more ACES is associated with higher incidence of chronic illness. Considering the cross-project impacts of ACH activities, reducing chronic illness is an additional equity benefit of success reducing opioids use disorder and death.

How Better Health Together will ensure that health equity is addressed in the project design

Better Health Together is ensuring that health equity is embedded in the project design at multiple levels:

- *Regional Health Transformation Collaboratives:* With the creation of distinct Spokane County and Rural Collaboratives, BHT is ensuring attention and focus to rural health issues and disparities in our region. In addition, we are designing these Collaboratives to include organizations that bring diverse racial and cultural perspectives to key regional health issues.
- *Community Voices Council:* BHT ACH is launching a Community Voices Council, made up of at least 50% Medicaid beneficiaries or low-income community members, to empower and bring consumer voices to inform project design and implementation. This Council will be tasked with developing health equity metrics by which to hold the Collaboratives and projects accountable to defined health equity goals and standards
- *Target populations:* BHT ACH is focusing projects on target populations experiencing the greatest health disparities. We are applying an “equity lens” to all our work by disaggregating data by race/age/ethnicity/sex/zip code wherever possible, both to make informed decisions about target populations and to monitor impact of projects across diverse groups. BHT ACH will supply Collaboratives with regional data to guide early assessments of Collaborative partners, and will direct these teams to identify populations within their county that face a high level of disparities and/or present as highly complex or high risk.
- *Lived experience:* With the Community-based Care Coordination project, BHT ACH is advancing the Pathways model and use of Community Health Workers with lived experience of health inequities to further our efforts. Care coordinators are critical to developing trust and culturally-appropriate strategies to meet the needs of our target populations across the MTD project areas.
- *Equity Accelerator Payment:* We anticipate implementing this incentive to support providers who serve a greater proportion of high-risk clients. The metrics tied to these payments will be determined by the Waiver Finance Workgroup, vetted by Provider Champions Council and Community Voices Council, finalized by Waiver Finance Workgroup, and recommended to the BHT Board.
- *Pathways Model:* Health equity is built into many elements of our Care Coordination strategy and the Pathways model, through individualized care plans; standards of care and access to the entire network of care agencies partnering with the Hub; culturally-informed care; and data infrastructure tools that can be used to monitor care practice, provider quality, and resource.

Project’s lasting impacts and benefit to the region’s overall Medicaid population

Opioid use is a public health crisis across the state and in our region. Addressing this crisis through increased prevention, treatment, overdose prevention and long-term recovery is vital to transformation the health care delivery system and using limited dollars more effectively. BHT ACH will support care transformation and payment redesign through its Collaboratives. The Collaboratives’ diverse partners and community voices will spur regional efforts to transform clinical care delivery, transition and divert individuals out of emergency departments and jails, and coordinate care. The activities in the opioid project are a key element of this overall strategy, with efforts to support clinical care, addiction treatment and other services for individuals with opioid addiction.

Implementation Approach and Timing

See Supplemental Workbook

Partnering Providers

See Supplemental Workbook

ACH Response

How Better Health Together has included partnering providers that collectively serve a significant portion of the Medicaid population

As referenced above, BHT ACH surveyed organizations in the region to complete a Health Systems Inventory (HSI) or Care Coordination Inventory (CCI) to gather provider information about existing work in the region related to the MTD project areas. BHT ACH received responses from 42 organizations, including major hospital networks, provider systems, FQHCs, MCOs, and care coordination agencies.

Responding providers for the Health Systems Inventory (HSI) represented more than 80 percent of the highest (top 10) volume Medicaid billers in primary care, mental health/substance use disorder, inpatient and ED. For several settings in BHT’s five rural counties, the HSI respondents represent *all* the Medicaid billers with claims or beneficiary counts of more than 10 in 2016.

Better Health Together staff are following up with non-represented providers serving a significant number of Medicaid clients, particularly substance use disorder treatment providers.

Process for ensuring partnering providers commit to serving the Medicaid population.

In 2018, BHT ACH will formalize partnering provider participation in the community-based care coordination project and other MTD project areas through a Transformation Compact

process to ensure commitment to serving the Medicaid population. BHT ACH has already engaged providers in the region serving a significant portion of the Medicaid population and has confidence in their continued commitment, but the Transformation Compact will formalize that expectation.

Process for engaging partnering providers that are critical to the project's success, and ensuring that a broad spectrum of care and related social services is represented

Better Health Together has identified that representation from the following sectors is required for Collaboratives to successfully implement projects. Each of these partners represent a critical setting for project implementation:

- Physical Health Clinical Provider(s)
- Hospital System (to include an ED Doctor)
- Behavioral Health Clinical Provider(s)
- Tribal Health Systems
- Emergency Medical Services (first responders)
- Criminal Justice
- SUD Provider(s)
- Community-Based Chronic Disease Prevention and Mitigation Organization
- Community Based Care Coordinating Agency
- MCO(s)
- Crisis Management Services
- Liaison: Community Member/Consumer

The Collaboratives will identify additional critical partners needed to develop and implement their projects, and Collaborative partnerships may be expanded as needed. In its role as the Pathways Hub, the BHT ACH will serve as a connector between collaborative providers and additional social and community partners that can help improve community health.

How Better Health Together is leveraging MCO's expertise in project implementation, and ensuring there is no duplication

Managed Care Organizations (MCOs) are actively involved in BHT's governance and leadership groups:

- Two MCO representatives, from Molina Health Care of Washington and Coordinated Care of Washington, are on the Board.
- All five MCOs are voting members of BHT's Leadership Council and MCO staff participate in meetings and one-on-one sessions with the BHT ACH team.
- BHT's Regional Integration Planning Team, supporting FIMC

MCOs will continue to participate in MTD project planning via these leadership groups and through targeted collaboration with BHT's Health Transformation Collaboratives.

In addition, BHT ACH, Pierce County ACH, and Southwest ACH have collaborated on meetings with MCO partners to learn about key crossover areas between ACHs and MCO under the MTD, to ensure that BHT's project strategy, support for providers/Domain 1 strategies, and monitoring and quality improvement efforts align with existing MCO activities and goals. Our discussions covered:

- Members/population overview

- PCP assignment/empanelment
- Provider support, particularly for value-based payment and related delivery system reform
- Measurement and quality improvement
- Member engagement/education
- Pathways Community Hub

MCOs emphasized the importance of considering the needs and utilization patterns of different Medicaid populations (e.g. expansion adults vs. traditional Medicaid) and designing strategies that can integrate additional groups (e.g. dual special needs clients) over time to fully engage MCOs and other partners and support sustainability. Another common point was the need to avoid overwhelming providers who are receiving assistance and requests for practice changes across payers and payment models. The BHT ACH and the Collaboratives can play a key role in coordinating TA support with MCOs. We also discussed ways to coordinate on data sharing with MCOs, HCA, the Washington Health Alliance, OneHealthPort and eventually the Washington All Payer Claims Database.

Regional Assets, Anticipated Challenges and Proposed Solutions

ACH Response

Assets the ACH and regional partners providers will bring to the project

- *Engaged partners:* The clinical and other partners on the Collaboratives and sub-committees are highly engaged in understanding key regional health needs and understanding how gaps can be resolved through collaborative action. In addition, the Washington Dental Services Foundation has expressed concern and interest in the opioids issue, recognizing that dental providers are a large source of opioid prescriptions. The Foundation's effort to establish a task force are being connected to the Collaborative efforts in order to ensure that knowledge and resources are combined rather than duplicated.
- *Financial Assets.* Empire Health Foundation pledged \$240,000 to ACH efforts in 2017. The region has two large non-profit hospitals that have histories of generous community benefit giving. In July 2017, BHT ACH renewed its 5-year contract with the Washington State Health Benefit Exchange to administer the regional Navigator Network.
- *Data Assets.* Spokane Regional Health District has given staff time to build the Community Linkage Map. It has also offered additional in-kind data and analytics support for Community Strategy Maps. In their responses to the HSI, the majority of potential partners expressed willingness to share data for planning and evaluation.
- ARCORA efforts to develop an Oral Health Local Impact Network that includes an Opioid Task Force chaired by SRHD Administrator and BHT Board member, Torney

Smith, to support alignment across oral health, physical, substance use providers.

Challenges and barriers to achieving outcomes and strategies for mitigating risks

The challenges in the BHT ACH region include:

Challenge / Barrier	Strategy
Provider Shortage/Service shortage especially in rural areas	Changes to the funding structure from BHO to managed Integrated care will dramatically assist in creating a more coordinated approach for managing care and it is expected will assist in creating more avenues for care as more integrated practices will be able to offer both mental health and substance use services under their MCO contract. Additionally, working with the Workforce Development Council, Community College and Eastern WA School of Social to expand the credential professionals available. Explore innovative ways to provide more support to get providers in training certified quicker.
Lifestyle barriers, unsafe neighborhoods, lack of family wage jobs	Work with local partners to align health of the community with Economic Development plans for diversifying economic opportunities (Pend Oreille County recruitment of Hi Test to provide 100 family wage jobs), Parks and Recreation efforts to provide more community opportunities (Ferry County Health Coalition has a summer activities schedule for teens and 20s to keep engaged) and other community
Stigma around medication use and asking for help in smaller communities	Seek educational resources to address public perception of mental health treatment and medication management to alleviate stigma.
Concentration of resources in Spokane, which means Spokane partners could be overwhelmed by asks from rural partners – how to scale into rural areas	Through the development of rural county-based collaborative, build stronger referral networks with Spokane services and further explore expansion of appropriate level of services.

Better Health Together is explicitly focusing on local needs and resources. This allows BHT ACH to promote solutions from the ground up. Collaboratives will identify community-level social determinants of health that are problematic. Education of providers, consumers and community members will help increase understanding about the causes of opioid misuse, alternatives for pain treatment and opportunities to receive treatment and recovery

assistance. Tackling stigma is a key part of overcoming the other barriers facing our region.

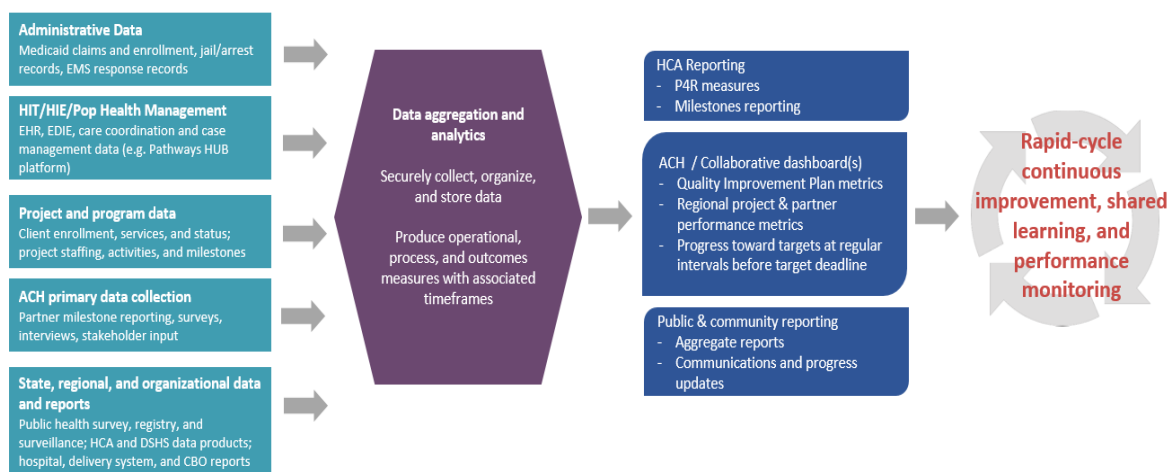
We will support Collaborative efforts to expand culturally competent and informed care. CHWs are a large part of this strategy. Peer supports can provide information and a trusted source. We prioritize best fit care coordinators who will ensure culturally competent care.

Monitoring and Continuous Improvement

ACH Response

The goal of BHT's monitoring plan is to use timely data to support project implementation, peer learning, and continuous improvement. BHT ACH will work with its contracted data vendor, Providence Center for Outcomes Research & Education (CORE), to design and implement a monitoring system that will track operational, process, and outcome measures for each project and Collaborative (see below) and for the ACH overall. The system will be designed to complement existing data assets (such as the Healthier Washington Data Dashboards, any FIMC early warning system, and relevant regional reports) and will refresh anytime a particular data feed is updated. Design will take place alongside implementation plan development in late 2017 and early 2018, so that the system is ready as projects move into implementation. A visual overview of BHT's planned approach to monitoring and continuous improvement is shown below.

Planned approach for monitoring and continuous improvement



Monitoring metrics will include ACH toolkit pay-for-reporting and pay-for-performance metrics, as well as regional accountability and quality improvement plan metrics that speak to the effectiveness of BHT's strategies within and across project areas. For the implementation phase, many metrics will be process or operational in focus (e.g. establishment of cross-setting data sharing agreements among Collaborative partners.) Final metrics will be identified in the implementation plan.

For the Opioids Project, BHT ACH will be tracking, at a minimum, information on the following accountability measures:

- Outpatient Emergency Department Visits per 1,000 Member Months
- Inpatient Hospital Utilization
- Patients on high-dose chronic opioid therapy by varying thresholds
- Patients with concurrent sedatives prescriptions
- Substance Use Disorder Treatment Penetration (Opioid)

The BHT ACH has set ambitious stretch goals of increasing by 10 percent over five years the proportion of Medicaid members whose mental health or substance use disorder treatment needs are met.

Plan for monitoring project implementation progress, including addressing delays in implementation

Those process measures will be associated with timeframes and benchmarks identified by the ACH and its Collaboratives to provide immediate feedback when delays occur. The BHT ACH plans to work with CORE to develop a community dashboard to monitor key metrics identified in the MTD and our community priorities. This will be a multi-functional dashboard extending beyond the MTD to allow ongoing community tracking and prioritization. Responsibility for addressing delays in implementation will lie with the Collaboratives, BHT governance bodies, and select BHT ACH staff positions as described under ‘Plan for monitoring continuous improvement’ below.

Plan for monitoring continuous improvement, supporting partnering providers and determining whether or not BHT is on track to meet expected outcomes

A monitoring and continuous improvement system is more than just data; it’s about the people, processes, and tools used to turn that data into actionable information that supports shared learning and quality improvement. In addition to creating a system to access and analyze data from different sources, BHT ACH will rely on the following groups and positions to interpret the data, identify performance shortcomings or risks, and develop solutions:

- **Community Health Transformation Collaboratives.** As described elsewhere, BHT is launching a Spokane County Collaborative and a Rural Collaborative to develop and implement specific regional plans for health system transformation in the four project areas BHT has selected. The Collaboratives’ role will extend to: advising on design of the self-monitoring system; regularly reviewing the data that system provides; collaborating with the ACH to make course corrections as needed; and participating in shared learning opportunities within and across Collaboratives and ACH regions.
- **Provider Champion Council (PCC).** This recently established Council will provide general clinical expertise and subject matter expertise in different MTD project areas. The Council will monitor trends in performance across the Collaboratives to assess whether the BHT ACH is on track to achieve expected outcomes and will advise on the Collaboratives’ proposed risk mitigation and continuous improvement strategies. The

PCC will also monitor individual Collaborative partners and advise on technical assistance necessary.

- BHT's **Director of Clinical Integration**, a position currently in recruitment, will support the clinical strategies for Bi-Directional Integration, Opioids, Chronic Disease and Care Coordination. Additionally, will staff the Provider Champion Council and identify, communicate, and address challenges to clinical integration and other transformation strategies.
- Jenny Slagle, Associate Director for Health System Transformation will serve as the **Pathways Hub Director** overseeing all operations of the hub including training, quality assurance and improvement and strategic direction. Jenny will staff the Pathways Community Council that will launch in 2018. This position will closely monitor the data available from the Hub platform and intervene when Pathways are slow to complete or have encountered roadblocks.
- In its role as monitoring system lead, **CORE** will coordinate with BHT ACH staff and the entities above to provide timely information, data interpretation expertise, and both technical and strategic support for peer learning and continuous improvement.
- BHT's Board will receive monthly dashboards on key milestones and plans to address any risks
- BHT's Regional Integration team will also track key milestones specifically tied to FIMC and MTD project alignment

Plan for addressing strategies that are not working or not achieving outcomes

In combination, the people and workgroups described above and timely data from the monitoring system will enable BHT ACH and its partnering providers to identify strategies that are not working and to think through solutions in time to achieve project outcomes. If necessary, potential adjustments to implementation timelines will be triaged through the monitoring system to assess their impact on downstream goals. If timelines still cannot be met, BHT ACH will inform the state about the reasons and its plan for adapting the timeline, and preventing/risk mitigation strategies will be shared to other programs where appropriate.

Project Metrics and Reporting Requirements

Attest that the ACH understands and accepts the responsibilities and requirements for reporting on all metrics for required and selected projects. These responsibilities and requirements consist of:

- *Reporting semi-annually on project implementation progress.*
- *Updating provider rosters involved in project activities.*

YES	NO
-----	----

X	
---	--

Relationships with Other Initiatives

Attest that the ACH understands and accepts the responsibilities and requirements of identifying initiatives that partnering providers are participating in that are funded by the U.S. Department of Health and Human Services and other relevant delivery system reform initiatives, and ensuring these initiatives are not duplicative of DSRIP projects. These responsibilities and requirements consist of:

- *Securing descriptions from partnering providers in DY 2 of any initiatives that are funded by the U.S. Department of Health and Human Services and any other relevant delivery system reform initiatives currently in place.*
- *Securing attestations from partnering providers in DY 2 that submitted DSRIP projects are not duplicative of other funded initiatives, and do not duplicate the deliverables required by the other initiatives.*
- *If the DSRIP project is built on one of these other initiatives, or represents an enhancement of such an initiative, explaining how the DSRIP project is not duplicative of activities already supported with other federal funds.*

YES	NO
X	

Project Sustainability

ACH Response

Better Health Together's strategy for long-term project sustainability

Better Health Together is developing our Spokane County and Rural Community Health Transformation Collaboratives as a core strategy to establish long-term, cross-sector partnerships that advance health delivery system transformation and value-based payment models that support long-term change. BHT ACH is working to align data, funds flow, and model development to maximize the opportunity to integrate selected projects into a value-based model and weave together local resources and investment to reach this goal.

Project's impact on Washington's health system transformation beyond the Demonstration period

We envision that collectively developing locally-administered projects will have long-term, sustainable benefit for Medicaid recipients and other residents of our region. Improving providers, consumers and community members' understanding of the impacts of opioid use, potential for harm and alternatives for treatment of pain will reduce opioid reliance and OUD. This change will impact health care costs and free up clinical resources for other service needs. Additionally, reduced opioid dependence and use disorder will positively impact social factors, reducing ACEs and making communities safer for all residents.

Better Health Together is supporting broad-reaching, system-wide transformation in order to have lasting impacts and benefit the region's overall population, regardless of chosen target population(s) or selected approaches/strategies. Improving access to both SUD services and the longer-term clinical and supportive services that will keep affected Medicaid members healthy and less likely to must be tied to a payment structure tied to health outcomes and keeping populations healthier overall. The combination of improving care for participants and increasing culturally responsive access that brings people to needed services will impact costs. Reduced clinical costs tied to reimbursement for outcomes will be a model that can be replicated in the region and state without regard to payer. Provider acceptance of new payment models can be capitalized to expand to the commercial individual and small group markets.

¹ University of Washington Alcohol & Drug Abuse Institute (April 2015). Opioid Trends Across Washington State. See: <http://adai.uw.edu/pubs/infobriefs/ADAI-IB-2015-01.pdf>. Note that Adams County's rate was not calculated as the total cases in 2015 were fewer than 5.

² Source: HCA RHNI starter kit, see:

<https://wahca.app.box.com/s/mxpg8euzbjpdkmyuftzb4ri5v41ia8v9/folder/23928005433>

³ Revision responds to Question 3A from first round of independent review. We verified the BHT figures on the Washington Department of Health's Overdose Dashboard. Washington State rates are not provided directly on the Dashboard but were calculated by adding together the visit or death counts for each quarter in 2016 and dividing that figure by the statewide population estimate from the Office of Financial Management. The original submission contained an error in which a 2010 population denominator was used instead of 2016. Results of the corrected calculation are shown in the revised table.

⁴ Source: WA Drug Overdose Dashboard, see:

http://www.doh.wa.gov/Portals/1/Documents/2900/wa_ach_od_quarterly_2017Q1.zip. Next highest ACH for 2016 opioid overdose hospitalizations was SWACH at 23.1 events per 100,000 and next highest for 2016 opioid overdose ED visits was CPAA at 80 events per 100,000.

⁵ Washington Prescription Drug Monitoring Program, see:

<https://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/HealthcareProfessionsandFacilities/PrescriptionMonitoringProgramPMP/CountyProfiles>

⁶ Shah A, Hayes CJ, Martin BC. Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use — United States, 2006–2015. *MMWR Morb Mortal Wkly Rep* 2017;66:265–269.

DOI: <http://dx.doi.org/10.15585/mmwr.mm6610a1>.

⁷ HCA RHNI "starter kit," see: <https://wahca.app.box.com/s/mxpg8euzbjpdkmyuftzb4ri5v41ia8v9/folder/23928005433>

⁸ Washington Prescription Drug Monitoring Program, see:

<https://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/HealthcareProfessionsandFacilities/PrescriptionMonitoringProgramPMP/CountyProfiles>

⁹ Washington Tracking Network (WTN), see:

<https://www.doh.wa.gov/DataandStatisticalReports/EnvironmentalHealth/WashingtonTrackingNetworkWTN>

SECTION II: PROJECT-LEVEL

Transformation Project Description

Select the project from the menu below and complete the Section II questions for that project.

Menu of Transformation Projects	
Domain 3: Prevention and Health Promotion	
X	3D: Chronic Disease Prevention and Control

Project Selection & Expected Outcomes

ACH Response

Project Description and Justification

Since the inception of the Better Health Together Accountable Community of Health, prevention has been a cornerstone of efforts to improve community health. The BHT ACH selected the Chronic Disease Prevention and Control Medicaid Transformation Demonstration (MTD) project to accelerate our efforts to improve health, with an initial focus on control and prevention of Type 2 diabetes. The project strategies include: increasing access to care; educating consumers and their families; identifying risk earlier, increasing coordination of services that link clinical providers and services to social supports and other service needs; and working with the state to support healthy choices for Washington residents. The BHT ACH is also exploring the possibility of focused efforts around prevention and management of asthma among youth and will make final decisions about project activities and target populations in consultation with its Collaboratives and Technical Councils.

The Community Health Transformation Collaboratives will be required to develop a MTD implementation plan for chronic disease care prevention and mitigation strategies in the Primary Care, Pediatric and Family Medicine settings and potentially a Behavioral Health setting. The projects will utilize the Chronic Care Model. Each Collaborative will align of the model with their Providers, Medicaid population and other factors influencing care in the area. This alignment includes, but is not limited to, the Community Guide, Stanford Chronic Disease Self-Management Program, and CDC-recognized National Diabetes Prevention Programs as well as supporting where possible, implementation of diabetes programs specific to Tribal Health Providers. We expect that each Collaborative will also develop a regional approach to Community Paramedicine, as these locally designed, community-based solutions could extend the reach of chronic disease management through the utilization of the skills of paramedics and emergency medical services (EMS) systems to address gaps that are identified through community level needs assessment.

Most efforts to tackle chronic disease are aimed at responding to the symptoms and negative consequences of those diseases. The BHT ACH seeks to work upstream, to help people avoid

chronic diseases. The MTD project will include a focus on early detection and intervention for individuals at risk for diabetes, and on reinforcing healthy lifestyle habits early in life. This will include efforts to:

- Educate people about opportunities to include physical activity in daily life, how to choose and prepare healthy, fresh foods.
- Increase the involvement of schools and workplaces, helping these institutions to implement practices that encourage healthy lifestyle, and reinforce healthy norms.
- Supporting programs and incentives that promote healthy choices.

This project will also align efforts with the bi-directional integration efforts to integrate health system and community approaches to improve chronic disease management and control for high priority populations. Projects were selected to support delivery system transformation efforts aimed at developing a sustainable business model for investment in prevention, management and linking of health care to social determinants of health. The MTD project for Chronic Disease will prepare the region to thrive in a Value Based Payment environment and support long term sustainability for prevention efforts.

Type 2 Diabetes was selected as a priority condition for the Chronic Disease project because of the physical and financial burden it represents for individuals and the health care system. Stakeholders in the BHT/ACH region highlighted obesity and diabetes in early community conversations and health system partners commonly cited Type 2 Diabetes as a condition where improved integration and coordination of care could lead to better health and financial outcomes.

Diabetes is the 7th leading cause of death in Washington State.¹ While the growth in diagnoses cases of diabetes has slowed since 2011, an estimated 2 million adults are pre-diabetic and as many as 30% of them will develop Type 2 diabetes within 5 years.² The Centers for Disease Control and Prevention estimate that diabetes costs the national about \$245 billion each year due to medical care, disability, and premature death.³

The BHT ACH region has higher than average rates of several risk factors for diabetes and related chronic conditions, as shown in the table below:

Table 1: Chronic Disease Risk Factors

Chronic disease risk factors	BHT	Washington
Poor nutrition	12%	10%
Insufficient physical activity	41%	38%
Smoking	18%	15%
Use e-cigarettes	7%	6%
Obesity	30%	27%

Similarly, the BHT region's rate of hospitalizations related to Diabetes is higher than the state average (1,200 per 100,00 vs. 1,096 per 100,000 statewide). Among ACH regions, the BHT

ACH had the third-highest age-adjusted rate of diabetes related deaths in 2015 (77 per 100,000, which is substantially higher than the state average of 71.6 per 100,000).⁴ Pend Oreille and Stevens County rates are higher, and the Adams County rate for 2015 was a staggering 203 per 100,000.⁵

How Project will support sustainable health system transformation for the target population

Strengthening the region's ability to prevent and manage chronic disease, particularly Diabetes will result in higher quality care, improved health outcomes and cost savings for the target population. By investing in the capacity of providers to better identify and manage Diabetes, we expect to be able to reduce long-term costs and improve population health. We will launch our efforts by ensuring that providers in the primary care setting have adequate process, tools and capacity in place to support identification and management. We will expand our efforts to also work with behavioral health, EMS and other community providers to ensure regularly tracking of key health indications (A1C levels, etc.) and ensure support services to ensure access to healthy foods and regular physical activities. Additionally, we expect to leverage the Community Health Workers Network of Eastern Washington as well as our Community Voices Council to build a community level movement to encourage healthy behaviors.

How Better Health Together will ensure project coordinates with and doesn't duplicate existing efforts

Better Health Together is supporting the development of two Community Health Transformation Collaboratives:

1. Rural Collaborative (comprised of Ferry, Stevens, Pend Oreille, Lincoln, Adams counties)
2. Spokane County Collaborative

The BHT ACH is taking a regional approach to project design and implementation that will provide local autonomy and regional accountability. The Collaboratives will be responsible for developing and implementing actionable MTD plans across BHT's project portfolio, and ensuring that the projects coordinate with each other and do not duplicate existing efforts in the region. The Collaboratives will be comprised of key partners with the expertise and experience required to transform our Medicaid Delivery System including clinics, Federally Qualified Health Centers (FQHCs), Hospitals, Mental health and Substance Use providers, Public Health, Tribal Health systems, EMS, Jails and County Commissioners. This representation will ensure efforts are coordinated across the region and resources are leveraged.

Anticipated Project Scope

Target Population. Individuals with Type 2 diabetes are the initial target population for the chronic disease prevention and control project, this group provides a promising focus to build systems to improve access, care, and outcomes for all individuals with chronic disease in the region. Each Collaborative will develop an integrated plan to address the target population

based on data from individual counties. We anticipate an additional emphasis on individuals with co-morbidity of behavioral health and Diabetes. We see an additional opportunity for engagement with individuals with behavioral health needs for the population targeted in the bi-directional integration MTD project. To proceed with this deepened focus, we will analyze data to assess the overlap between diabetes and depression among BHT's Medicaid population. Potential efforts may include flagging individuals at appointments to ensure that they are assessed and treated for unmanaged diabetes and presenting behavioral health symptoms.

The Center for Outcomes and Research and Evaluation (CORE) estimates that between 5,800 and 7,500 Medicaid-covered adults in the region have Diabetes. The low-end estimate is based on individuals with 24 months of continuous eligibility, which is probably an undercount given the number of people who cycle on and off Medicaid over a two-year period.⁶ The estimated prevalence rate of diabetes among BHT area Medicaid beneficiaries overall is 3% but varies slightly between 3% and 4% among BHT's counties and among different race and ethnicity groups. Individuals who identify their preferred language as Russian have a slightly higher rate of 5%. (Note that the numerator inclusion criteria for all of these estimates require at least one inpatient or two outpatient claims with a diagnosis of diabetes in the last year, so diabetics who are not in care are not captured.)⁷

As noted earlier, the BHT ACH is also considering a suite of chronic disease prevention and control activities related to childhood asthma and will finalize this decision in consultation with partners in the coming months. Three percent of Medicaid enrollees under the age of 19 have a diagnosis of asthma in BHT's region; this translates into approximately 2600 children. Rates are elevated in Spokane and Stevens counties, and among American Indian/Alaska native individuals.⁷

Strategies. While the Collaboratives will adopt strategies that work best for their communities, the BHT ACH is supporting a number of key strategies to promote member health and move toward a sustainable, transformed system, including:

- **Self-Management Support**, including strategies and resources to provide targeted members the resources they need to better manage their health and health care. Examples of these efforts include Diabetes Self-Management Education and the Stanford Chronic Disease Management Program. Several Stanford-model programs exist in the region now, supporting home-based blood pressure monitoring; provide motivational interviewing; ensure cultural and linguistic appropriateness. In addition, Empire Health Foundation has a medication management program that we will extend the MTD effort and investment.
- **Delivery System Design** strategies support effective, efficient care by implementing and supporting team-based care strategies, increasing the presence and clinical role of non-physician members on the care team, increasing frequency and improving processes of planned care visits and follow-up, and establishing or improving referral processes to care management and specialty care. We will utilize Pathways Community Hub care coordination model to reduce risk factors and support increased engagement, follow up, and reduction of barriers.
- **Clinical Information Systems** strategies will organize patient and population data to

facilitate efficient and effective care, such as: utilization of patient registries; automated appointment reminder systems; bi-directional data sharing and encounter alert systems; provider performance reporting.

- **Community-based Resources and Policy** strategies will activate the community, increase community-based supports for disease management and prevention, and support development of local collaborations to address structural barriers to care. We will develop diabetes-specific MOUs with community based organizations to support people discharged from the hospital for diabetes related services, offer pre-diabetes screenings to increase help for people with early need, and connect Medicaid enrollees to local resources. In addition to the previously discussed food bank classes, we will connect with other education based services and supports such as the Empire Health Foundation sponsored fitness class for elders, with a goal of increasing wellness, fitness, exercise and education.
- **Health Insurance Access:** In 2013, BHT developed the **Navigator Network**, a large and successful initiative to provide In-Person Assistants to enroll people in Apple Health (Medicaid) and Qualified Health Plans on the Washington Health Benefit Exchange. Through these efforts, BHT successfully enrolled over 125,000 people in health insurance, many of whom have behavioral health diagnoses, and developed a robust network of partners throughout the region. The BHT/ACH will work to maximize enrollment coverage for the community.

Involvement of Partnering Providers

We launched the MTD project development process by requesting stakeholders submit an optional letter of interest to identify potential partners and where they are located. We received responses from providers in each County indicating interest in all the optional projects. We also used data from Health System Inventories (HSI) to understand the level of need and resources at the local level.

The following providers and community organizations responded to the call for letters of interest (LOI) with an LOI for Project Implementation or Project Partnership:

Aging and Long-Term Care of Eastern Washington	Northeast Tri County Health District
Catholic Charities Spokane	Odessa Memorial Healthcare Center
CHAS Health	Operation Healthy Family
Communities in Schools	Oral Healthcare LLC
Consistent Care Services, SPC, PS	Othello Community Hospital
Community Health Plan of Washington	Pend Oreille Health Coalition
East Adams Rural Healthcare	Pioneer Human Services
Ferry County Public Hospital District	Planned Parenthood
Empire Health Foundation	Providence Health Care
Frontier Behavioral Health	Rural Resources Community Action
Greater Spokane County Meals on Wheels	SNAP
Inland Northwest Health Services	Spokane Neighborhood Action Partners
Kalispel Tribe of Indians	Spokane Regional Health District

Lake Roosevelt Community Health Centers
Lincoln County Health Department
Merit Disability
National Alliance on Mental Illness
NHHS/ Pend Oreille Health Coalition

Virginia Matheny
Washington Dental Service Foundation
YMCA
YWCA

To develop the proposed Chronic Disease MTD project, the BHT ACH convened and met one-on-one with high volume and engaged partnering providers throughout the region working on chronic disease. In addition, the BHT ACH engaged providers a Health Systems Inventory (HSI) and a Care Coordination Inventory (CCI), to identify provider interest in the chronic MTD project areas. Draft inventories were first released for public feedback, and once launched, we hosted 3 webinars to overview the Inventory and answer any questions from partners. BHT staff hosted 15 hours of Office Hours sessions where providers could drop in and talk with ACH staff about their Inventories or MTD, in addition to numerous outreach meetings to individual provider organizations.

39 organizations in the BHT ACH region, representing most major health and social service systems, completed the Health Systems Inventory (HSI) and/or Care Coordination Inventory (CCI). These efforts directly informed the development of the proposed Chronic Disease project priorities and the BHT ACH proposal to develop regional Collaboratives to implement MTD projects.

Level of Impact

We envision that by collectively developing sustainable projects at the local level, Medicaid recipients and other residents will benefit long-term with improved health outcomes while bending the cost curve. Diabetes prevention and control is an expensive issue that presents a big opportunity for savings and to demonstrate the benefit of clinical-social services connections. Diabetes impacts overall health, and is impacted by a variety of social and environmental factors. Reducing diabetes incidence will greatly reduce health care needs and costs. At the same time efforts to impact diabetes will also impact other health and social risk factors.

Approximately 58,000 people in BHT's service area have diabetes.⁸ By focusing on improving access to care and services for Medicaid members, we can change how clinical and social services providers support all diabetics in the region. BHT Collaboratives will focus initially on improving diabetes management processes as prioritized by the MTD performance measures – increasing the proportion of diabetics who receive annual blood glucose tests, kidney function tests, and eye exams for retinopathy – as well as on improving access to and coordination of care. There is substantial room to improve on the annual eye exam measure, where both BHT and statewide performance for Medicaid are well below national benchmarks. We estimate that we will need to ensure that at least 175 *additional* Medicaid members with diabetes in the BHT region receive annual eye exams in order to meet demonstration performance targets.

How Better Health Together will ensure that health equity is addressed in the project design

Current data does not suggest any significant racial/ethnic, geographic, or gender disparities in diabetes prevalence among Medicaid beneficiaries in BHT's region. However, disparities do exist in diabetes management. The table below shows 2016 performance on three diabetes care quality measures by county, race, and ethnicity. Yellow shading indicates that the performance is more than 1% below the BHT region average. BHT will assist its Collaboratives to review local data and develop strategies for improving equity in diabetes management in their areas.

Table 2: Diabetes Quality of Care Measures for Medicaid, 2016⁹

	HbA1c testing	Diabetic Eye Exam	Diabetes Kidney test
County			
Adams	87%	47%	90%
Ferry	92%	24%	94%
Lincoln	84%	37%	88%
Pend Oreille	83%	21%	77%
Spokane	82%	28%	87%
Stevens	82%	23%	84%
Ethnicity			
Hispanic	83%	34%	87%
Not Hispanic	82%	28%	86%
Unknown	86%	29%	88%
Race			
AI/AN	79%	36%	88%
Asian	82%	41%	83%
Black	71%	31%	89%
NH/PI	75%	35%	86%
White	83%	27%	86%
Multiracial	82%	39%	82%
Other	83%	35%	85%
Unknown	89%	32%	89%
BHT overall	83%	29%	86%
State	84%	30%	86%

Better Health Together ACH is ensuring that health equity is embedded in the project design at multiple levels:

- *Regional Health Transformation Collaboratives:* With the creation of distinct Spokane

County and Rural Collaboratives, BHT is ensuring attention and focus to rural health issues and disparities in our region. In addition, we are designing these Collaboratives to include organizations that bring diverse racial and cultural perspectives to key regional health issues.

- *Community Voices Council:* BHT ACH is launching a Community Voices Council, made up of at least 50% Medicaid beneficiaries or low-income community members, to empower and bring consumer voices to inform project design and implementation. This Council will be tasked with developing health equity metrics by which to hold the Collaboratives and projects accountable to defined health equity goals and standards.
- *Target populations:* BHT is focusing projects on target populations experiencing the greatest health disparities. We are applying an “equity lens” to all our work by disaggregating data by race/age/ethnicity/sex/zip code wherever possible, both to make informed decisions about target populations and to monitor impact of projects across diverse groups. BHT will supply Collaboratives with regional data to guide early assessments of Collaborative partners, and will direct these teams to identify populations within their county that face a high level of disparity and/or present as highly complex or high risk.
- *Lived experience:* With the Community-based Care Coordination project, the BHT ACH is advancing the Pathways model and use of community care coordinators with lived experience of health inequities to improve care. Care coordinators are critical to developing trust and culturally-appropriate strategies to meet the needs of our target populations across the MTD project areas.
- *Equity Accelerator Payment:* We anticipate implementing this incentive to support providers who serve a greater proportion of high-risk clients. The metrics tied to these payments will be determined by the Waiver Finance Workgroup, vetted by Provider Champions Council and Community Voices Council, finalized by Waiver Finance Workgroup, and recommended to the BHT Board.
- We will also seek to connect our chronic disease project work to larger systemic work to affect Adverse Childhood Events (ACEs). Having one or more ACEs is associated with higher incidence of chronic illnesses including obesity, cardiovascular disease, hypertension, and high cholesterol.¹⁰ Our focus on a population with disproportionate impact of chronic illness is one way to help disproportionately affected populations. The BHT ACH also sees an opportunity to support intergenerational knowledge transfer. As individuals with diabetes improve their chronic disease self-management through education on healthy food preparation, they share this knowledge and experience with their families. Promoting healthy choices through education and trusted sources of information can impact more than the chronically ill individuals themselves, but can spread to their families and communities, extending the impact of interventions and supports.

Project’s lasting impacts and benefit to the region’s overall Medicaid population

Our goal is to facilitate health system transformation through the adoption of Value Based Payments and greater integration of community supports into clinical care. The increased use of community care coordinators and social services providers will improve access to chronic disease care for Medicaid consumers facing access barriers. The projects developed by the

Collaboratives will increase the use of cost-effective services and improve health outcomes. Clinical providers will see the impact of partnering with social determinant of health providers and both types of providers will receive VBP reimbursement that further promote integration of community supports.

Implementation Approach and Timing

See Supplemental Workbook

Partnering Providers

See Supplemental Workbook

ACH Response

How Better Health Together has included partnering providers that collectively serve a significant portion of the Medicaid population

In the Spring of 2017, providers and stakeholders were informed about the opportunity to improve population health for the Medicaid population. Interested organizations submitted an LOI indicating their level and type of interest (project implementation, project partnership) in MTD. The following providers and organizations expressed interest in Chronic Disease MTD project implementation (to serve as a partnering provider and implement the project) and/or partnership (to serve as a supportive partner).

Provider/Partnering Organization	LOI for Project Implementation	LOI for Project Partnership
Aging and Long-Term Care of Eastern Washington	X	X
Catholic Charities Spokane		X
CHAS Health	X	
Communities in Schools		X
Consistent Care Services, SPC, PS	X	
Community Health Plan of Washington		X
East Adams Rural Healthcare	X	
Ferry County Public Hospital District	X	X
Empire Health Foundation	X	
Frontier Behavioral Health	X	
Greater Spokane County Meals on Wheels		X
Inland Northwest Health Services	X	
Kalispel Tribe of Indians	X	
Lake Roosevelt Community Health Centers (Colville Tribe of Indians)		X
Lincoln County Health Department	X	

Merit Disability		X
National Alliance on Mental Illness		X
NHHS/ Pend Oreille Health Coalition		X
Northeast Tri County Health District	X	X
Odessa Memorial Healthcare Center	X	
Operation Healthy Family	X	X
Oral Healthcare LLC	X	
Othello Community Hospital	X	
Pend Oreille Health Coalition	X	
Pioneer Human Services	X	X
Planned Parenthood		X
Providence Health Care	X	X
Rural Resources Community Action	X	X
SNAP		X
Spokane Neighborhood Action Partners	X	
Spokane Regional Health District	X	X
Virginia Matheny	X	
Washington Dental Service Foundation	X	X
YMCA		X
YWCA	X	

Additionally, the BHT ACH surveyed organizations in the region to complete a Health Systems Inventory (HSI) or Care Coordination Inventory (CCI) to gather provider information about existing work in the region related to the Chronic Disease MTD project area. The BHT ACH received responses from 42 organizations, including major hospital systems, social service providers, FQHCs, MCOs, and care coordination agencies.

The BHT ACH compared the HSI respondents with HCA's September 2017 Provider Report and found that the inventory responses represent more than 80% of the highest (top 10) volume Medicaid billers in each major setting (primary care, mental health/substance abuse, inpatient and ED.) For several settings in the BHT ACH's five rural counties, the HSI respondents represent all the Medicaid billers with claims or beneficiary counts of more than 10 in 2016. BHT staff are following up with non-represented providers that see a large number of Medicaid clients, particularly substance abuse disorder treatment and Tribal health providers.

Process for ensuring partnering providers commit to serving the Medicaid population.

In 2018, the BHT ACH will formalize partnering provider participation in the community-based care coordination project and other MTD project areas through a Transformation Compact process to ensure commitment to serving the Medicaid population. BHT has already engaged providers in the region serving a significant portion of the Medicaid population and has confidence in their continued commitment, but the Transformation Compact will formalize that expectation.

Process for engaging partnering providers that are critical to the project's success, and ensuring that a broad spectrum of care and related social services is represented

The BHT ACH has identified that representation from the following sectors is required for Collaboratives to successfully implement projects. Each of these partners represent a critical setting for project implementation:

- Physical Health Clinical Provider(s)
- Hospital System (to include an ED Doctor)
- Behavioral Health Clinical Provider(s)
- Indian Health Systems
- Public Health
- Emergency Medical Services (first responders)
- Criminal Justice
- SUD Provider(s)
- Community-Based Chronic Disease Prevention and Mitigation Organization
- Community Based Care Coordinating Agency
- MCO(s)
- Crisis Management Services
- Liaison: Community Member/Consumer

Collaborative partnerships will be expanded as needed. In its role as the Pathways Hub, the ACH will serve as a connector between Collaborative providers and social and community partners. BHT is also launching a Provider Champions Council to lend a practicing provider perspective to our work and to inform and validate MTD Plans laid out by Collaboratives.

How Better Health Together is leveraging MCO's expertise in project implementation, and ensuring there is no duplication

Managed Care Organizations are actively involved in BHT's governance and leadership groups:

- Two MCO representatives, from Molina Health Care of Washington and Coordinated Care of Washington, are on the BHT Board
- All five MCOs are voting members of BHT's Leadership Council and MCO staff participate in meetings and one-on-one sessions with the BHT team
- Two MCO representatives are on the BHT's Regional Integration Planning Team, supporting FIMC

MCOs will continue to participate in Demonstration project planning via these leadership groups and through targeted collaboration with BHT's Health Transformation Collaboratives.

In addition, BHT ACH, Pierce County ACH, and Southwest ACH have collaborated on meetings with MCO partners to learn about key crossover areas between ACHs and MCOs under the MTD, to ensure that BHT's project strategy, support for providers/Domain 1 strategies, and monitoring and quality improvement efforts align with existing MCO activities and goals. Our discussions covered:

- Members/population overview
- PCP assignment/empanelment

- Provider support, particularly for value-based payment and related delivery system reform
- Measurement and quality improvement
- Member engagement/education
- Pathways Community Hub

MCOs emphasized the importance of considering the needs and utilization patterns of different Medicaid populations (e.g. expansion adults vs. traditional Medicaid) and designing strategies that can integrate additional groups (e.g. dual special needs clients) over time to fully engage MCOs and other partners and support sustainability. Another common point was the need to avoid overwhelming providers who are receiving assistance and requests for clinical practice changes across payers and payment models. The ACH and the Collaboratives can play a key role in coordinating TA support with MCOs. We also discussed ways to coordinate on data sharing with MCOs, HCA, the Washington Health Alliance, OneHealthPort and eventually the Washington All Payer Claims Database.

Regional Assets, Anticipated Challenges and Proposed Solutions

ACH Response

Regional Assets, Anticipated Challenges and Proposed Solutions

Assets the ACH and regional partners providers will bring to the project

The BHT ACH will utilize a Rural and Spokane County Collaborative model to develop and implement actionable chronic disease plans. The Rural Collaborative, covering 35,173 Medicaid lives in the rural counties of Adams, Ferry, Lincoln, Pend Oreille and Stevens; and the Spokane County Collaborative, a county with 164,707 covered Medicaid lives. These Collaboratives are responsible for developing a local set of strategies to meet the MTD project goals. The Collaborative structure will align with the proposed MTD funds flow approach by allocating earned regional funds to each Collaborative based on pay for reporting and pay for performance goal achievement. Funds flow strategies include plans for fixed and earned payments to both urban and rural provider partners to cover expenses such as project costs, project administration, provider engagement and participation, workforce development, population health management, and other costs.

Local Partner Assets. There are a number of local efforts that will serve as resources and models to build on for our Chronic Disease MTD project. We expect these organizations to be active in local planning and implementation at the Collaborative level.

YMCA of the Inland Northwest (Spokane) and Rural Resources Community Action (Pend Oreille, Stevens and Ferry Counties) are operating programs using the Stanford Chronic Disease model.

INHS is implementing a pilot project in two clinics implement Pre-Diabetes Risk Test with Patients and provide a direct referral to Diabetes Prevention Program (DPP). The DPP programs are offered

monthly and full with 15-18 people each time.

Empire Health Foundation and Spokane Tribe of Indians is operating multiple Chronic Disease projects in the region. Their longest running program, in partnership with the Spokane Tribe Health and Human services, EHF has created the proprietary “Coaching for Activation” tool (provided through the Patient Activation Measure license through Insignia Health) which identifies disease states and levels of activation to individually tailor programs for Spokane Tribal Elders. The pilot uses in-person health coaching focused on goal-setting and action planning which can include chronic disease management in addition to other personal health goals that the elder wants to accomplish.

Empire Health Foundation and local rural Pharmacists are piloting a set of Medication Management projects intended to explore adding care coordination capacity via local pharmacist in rural settings. The pilot population includes people with co-occurring conditions including diabetes.

Second Harvest and local food banks: In addition to offering healthy food to low income residents in the region, area Food Banks provide education, cooking classes and resources for individuals with diabetes. This is a valuable resource that can positively impact the lives of individuals with chronic illness and limited resources to support lifestyle changes needed to manage diabetes. In Spokane, residents can get walked through the food bank to get the foods that meet their health needs, and receive coaching on meal planning and healthy meal preparation. We will work to scale up community education activities such as the availability of cooking classes and diabetes friendly meals.

Spokane Regional Health District 1422: Over the past three years the Spokane region has participated in the 1422 Department of Health grant from the CDC to reduce Diabetes, Stroke, Heart Disease and Hypertension. This work includes powerful partnerships to be leveraged in our collaborative development with WSU School of Pharmacy, INHS Diabetes efforts and the Statewide Diabetes Network <https://diabetes.doh.wa.gov/>. We will be requiring each collaborative to align efforts with statewide recommended practices from the statewide Diabetes network and encouraging alignment with efforts being developed via INHS Diabetes Prevention and Management Program, YMCA Diabetes Prevention efforts and the 211 program for Diabetes

Data Assets. Spokane Regional Health District in-kind support included staff time to build the Community Linkage Map. It has also offered additional in-kind data and analytics support for Community Strategy Maps. In their responses to the Health System Inventory (HSI), the majority of potential partners expressed willingness to share data for planning and evaluation.

Clinical. Six clinical providers included in the HSI have clinical provider champions willing to donate time and expertise to project planning Collaboratives. Most potential care coordination agencies indicated they would donate staff time to training new workflows and models to meet requirements.

In-kind. Empire Health Foundation and Spokane Regional Health District provides convening space for partner meetings and ACH efforts For meetings outside of Spokane, our rural partners have donated meeting space and coordination support. We anticipate continued in-kind support for

meeting space, recruitment and volunteering. Partners have expressed willingness to donate staff and leadership time and expertise to support strategy development.

Challenges to improving outcomes and lowering costs for target population and strategy to mitigate risks and overcome barriers

The challenges in the BHT ACH region include:

- Provider shortages and challenge of increasing access, utilization and attachment to PCPs.
- Services shortage, especially supportive services in rural counties
- Lifestyle barriers, such as healthy food options where it is difficult or expensive to get fresh vegetables
- Unsafe neighborhoods with lack of access to safe places to exercise
- Concentration of resources in Spokane, which means Spokane partners could be overwhelmed by asks from rural partners – how to scale into rural areas
- HIT and HIE capacity varies by organization

Better Health Together's Strategy for mitigating the identified risks and overcoming barriers

BHT ACH is explicitly focusing on local needs and resources. This allows BHT to promote solutions from the ground up. Collaboratives will identify community-level social determinants of health issues that are problematic. For example, Ferry County requires a transportation resource to get low income residents to a grocery store. Innovative community efforts will be needed to tackle these local issues.

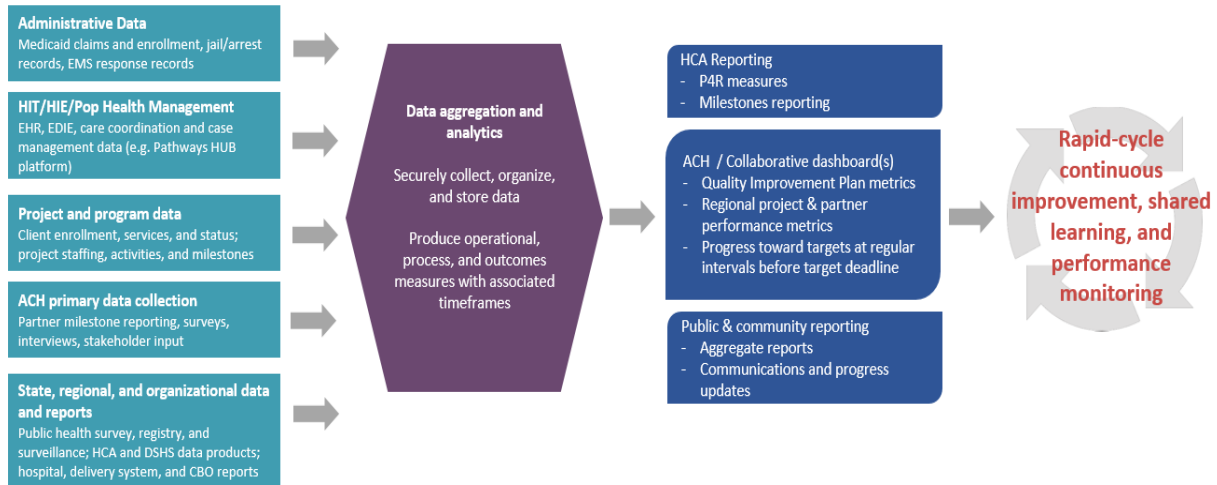
We will support Collaborative efforts to expand culturally competent care, such as targeting diabetes and wellness programs for the American Indian / Alaska Native populations to address relevant cultural motivators and needs. Community care coordinators are a large part of this strategy, because having a person with a shared lived experience will engage and motivate with individuals to overcome barriers. We will prioritize best fit care coordinators to ensure culturally competent care.

Monitoring and Continuous Improvement

ACH Response

The goal of BHT ACH's monitoring plan is to use timely data to support project implementation, peer learning, and continuous improvement. BHT ACH will work with its contracted data vendor, Providence Center for Outcomes Research & Education (CORE), to design and implement a monitoring system that will track operational, process, and outcome measures for each project and Collaborative (see below) and for the ACH overall. The system will be designed to complement existing data assets (such as the Healthier Washington Data Dashboards, any Fully Integrated Managed Care early warning system, and relevant regional reports) and will refresh anytime a particular data feed is updated. Design will take place alongside implementation plan development in late 2017 and early 2018, so that the system is ready as projects move into implementation. A visual overview of BHT ACH's planned approach to monitoring and continuous improvement is shown below.

Planned approach for monitoring and continuous improvement



Monitoring metrics will include ACH toolkit pay-for-reporting and pay-for-performance metrics, as well as regional accountability and quality improvement plan metrics that speak to the effectiveness of BHT ACH's strategies within and across project areas. For the implementation phase, many metrics will be process or operational in focus (e.g. establishment of cross-setting data sharing agreements among Collaborative partners.) Final metrics will be identified in the implementation plan.

For the Bi-Directional Integration Project, the BHT ACH will be tracking, at a minimum, information on the following accountability measures:

- Anti-depression medication management
- Child and Adolescents' Access to Primary Care Practitioners
- Comprehensive Diabetes Care: HbA1c Testing
- Comprehensive Diabetes Care: Medical attention for nephropathy
- Comprehensive Diabetes Care: Eye Exam (retinal) performed
- Medication Management for People with Asthma (5 – 64 Years)
- Mental Health Treatment Penetration (broad)
- Plan All-Cause Readmission Rate (30 Days)
- Substance Use Disorder Treatment Penetration
- Follow-up After Hospitalization for Mental Illness
- Follow-up After Discharge from ED for Mental Health
- Follow-up After Discharge from ED for Alcohol or Other Drug Dependence
- Inpatient Hospital Utilization
- Outpatient Emergency Department Visits per 1000 Member Months

Plan for monitoring project implementation progress, including addressing delays in implementation

As shown in the diagram, the system will incorporate process measures for project implementation. Those process measures will be associated with timeframes and benchmarks

identified by the ACH and the Collaboratives to provide immediate feedback when delays occur. The BHT ACH will work with CORE to develop a community dashboard to monitor key metrics identified in the toolkit and our community priorities. This will be a multi-functional dashboard extending beyond the MTD to allow ongoing community tracking and prioritization. Responsibility for addressing delays in implementation will lie with the Collaboratives, BHT governance bodies, and select BHT staff positions as described under 'Plan for monitoring continuous improvement' below.

Plan for monitoring continuous improvement, supporting partnering providers and determining whether or not BHT is on track to meet expected outcomes

A monitoring and continuous improvement system is more than just data; it's about the people, processes, and tools used to turn that data into actionable information that supports shared learning and quality improvement. In addition to creating a system to access and analyze data from different sources, the BHT ACH will rely on the following groups and positions to interpret the data, identify performance shortcomings or risks, and develop solutions:

- **Community Health Transformation Collaboratives.** As described elsewhere, BHT is launching a Spokane County Collaborative and a Rural Collaborative to develop and implement specific regional plans for health system transformation in the four project areas BHT has selected. The Collaboratives' role will extend to: advising on design of the self-monitoring system; regularly reviewing the data that system provides; collaborating with the ACH to make course corrections as needed; and participating in shared learning opportunities within and across Collaboratives and ACH regions.
- **Provider Champion Council (PCC).** This recently established Council will provide general clinical expertise and subject matter expertise in different MTD project areas. The Council will monitor trends in performance across the Collaboratives to assess whether the BHT ACH is on track to achieve expected outcomes and will advise on the Collaboratives' proposed risk mitigation and continuous improvement strategies. The PCC will also monitor individual Collaborative partners and advise on technical assistance necessary.
- **BHT's Director of Clinical Integration,** a position currently in recruitment, will support the clinical strategies for Bi-Directional Integration, Opioids, Chronic Disease and Care Coordination. Additionally, will staff the Provider Champion Council and identify, communicate, and address challenges to clinical integration and other transformation strategies.
- **Jenny Slagle, Associate Director for Health System Transformation** will serve as the **Pathways HUB Director** overseeing all operations of the hub including training, quality assurance and improvement and strategic direction. Jenny will staff the Pathways Community Council that will launch in 2018. This position will closely monitor the data available from the HUB platform and intervene when Pathways are slow to complete or

have encountered roadblocks.

- In its role as monitoring system lead, **CORE** will coordinate with BHT staff and the entities above to provide timely information, data interpretation expertise, and both technical and strategic support for peer learning and continuous improvement.
- The BHT Board will receive monthly dashboards on key milestones and suggested plans to address any risks
- BHT's Regional Integration team will also track key milestones specifically tied to FIMC and MTD project alignment

Plan for addressing strategies that are not working or not achieving outcomes

In combination, the people and workgroups described above and timely data from the monitoring system will enable the BHT ACH to identify strategies that are not working and to think through solutions in time to achieve project outcomes. If necessary, potential adjustments to implementation timelines will be triaged through the monitoring system to assess their impact on downstream goals. If timelines still cannot be met, BHT will inform the state about the reasons and its plan for adapting the timeline, and preventing/risk mitigation strategies will be shared to other programs where appropriate.

Project Metrics and Reporting Requirements

Attest that the ACH understands and accepts the responsibilities and requirements for reporting on all metrics for required and selected projects. These responsibilities and requirements consist of:

- *Reporting semi-annually on project implementation progress.*
- *Updating provider rosters involved in project activities.*

YES	NO
X	

Relationships with Other Initiatives

Attest that the ACH understands and accepts the responsibilities and requirements of identifying initiatives that partnering providers are participating in that are funded by the U.S. Department of Health and Human Services and other relevant delivery system reform initiatives, and ensuring these initiatives are not duplicative of DSRIP projects. These responsibilities and requirements consist of:

- *Securing descriptions from partnering providers in DY 2 of any initiatives that are funded by the U.S. Department of Health and Human Services and any other relevant delivery system reform initiatives currently in place.*
- *Securing attestations from partnering providers in DY 2 that submitted DSRIP projects are not duplicative of other funded initiatives, and do not duplicate the deliverables required by the other initiatives.*
- *If the DSRIP project is built on one of these other initiatives, or represents an enhancement of such an initiative, explaining how the DSRIP project is not duplicative of activities already supported with other federal funds.*

YES	NO
X	

Project Sustainability

ACH Response

Better Health Together's strategy for long-term project sustainability

BHT ACH is working to integrate health system and community approaches to improve chronic disease management and control. Working with the Collaboratives to develop projects that support transformative change, we are building a model that matches funding to the changes in care delivery. We will align mission and business by supporting long-term sustainable funding for services and activities that improve and support health. We considered regional health needs and community momentum in selecting chronic disease prevention and control as an MTD Project.

We are developing our Collaboratives with a focus on moving the region to Value Based Purchasing and whole person care. VBP is the cornerstone of our sustainability plan, recognizing the need to transition how we pay for care and linking social determinant of health services. We are working to align data, funds flow, and model development to maximize the opportunity to integrate selected projects into a value based model and weave together local resources and investment to reach this goal. For instance, it is expected that the Board's funds flow policy will include directed investments for startup costs, infrastructure and technical assistance emphasizing DSRIP funding for transition, not an ongoing payment stream.

Project's impact on Washington's health system transformation beyond the Demonstration period

The BHT ACH is supporting broad-reaching, system-wide transformation in order to have lasting impacts and benefit the region's overall population, regardless of chosen target population(s) or selected approaches/strategies. Changing how services are delivered for populations such as individuals with Type 2 diabetes will promote payment tied to health outcomes and keeping populations healthier overall. The combination of improving care for participants and increasing culturally responsive access that brings people to needed services will impact costs. Reduced clinical costs tied to reimbursement for outcomes will be a model that can be replicated in the region and state without regard to payer. Provider acceptance of new payment models can be capitalized to expand to the commercial individual and small group markets.

¹ Washington DOH, see:

<https://www.doh.wa.gov/DataandStatisticalReports/HealthStatistics/Death/DeathTablesbyTopic>

² Washington State Diabetes Epidemic and Action Report, 2017. See:

<https://www.doh.wa.gov/Portals/1/Documents/Pubs/345-349-DiabetesEpidemicActionReport.pdf>

³ Centers for Disease Control and Prevention. National Diabetes Statistics Report: Estimates of Diabetes and Its Burden in the United States, 2014. Atlanta, GA: US Department of Health and Human Services; 2014. Available from:

<http://www.cdc.gov/diabetes/data/statistics/2014StatisticsReport.html>.

⁴ Washington Tracking Network, see:

<https://www.doh.wa.gov/DataandStatisticalReports/EnvironmentalHealth/WashingtonTrackingNetworkWTN>. All rates include both men and women and are age-adjusted.

⁵ Same source as above. Small numbers in Adams County mean that the confidence interval around this estimate is wide, but the lower bound of the 95% CI is still 132 diabetes-related deaths per 100,000.

⁶ Varying estimates based on HCA Behavioral Health and Chronic Conditions files 9-29-17

(<https://wahca.app.box.com/s/mxpg8euzbjpdkmyuftzb4ri5v41ia8v9/folder/39866406519>) and Healthier Washington Data Dashboard, which use different continuous enrollment criteria.

⁷ Healthier Washington Data Dashboard, CY 2016 data. See: <https://www.hca.wa.gov/about-hca/healthier-washington/data-dashboard>

⁸ Estimate calculated by applying 10% self-reported prevalence rate from WA Dept. of Health ACH Chronic Disease Profiles to 2016 regional population estimates from WA Office of Financial Management.

⁹ Source: Healthier Washington Data Dashboard, CY 2016 data. See: <https://www.hca.wa.gov/about-hca/healthier-washington/data-dashboard>

¹⁰ 7.Felitti V, et al. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. *Am J Prev Med.* 14(4):245–258